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18-0373

GOVERNMENT OF GUAM
And
TakeCare Insurance Company, Inc.
GROUP HEALTH INSURANCE AGREEMENT
HSA 2000

October 1, 2017 – September 30, 2018

Preamble

This Agreement is made effective by and between the GOVERNMENT OF GUAM ("GovGuam") and TakeCare Insurance Company, Inc. ("Company"). The effective date of this Agreement is October 01, 2017.

Recitals

WHEREAS, Company is an insurance company duly licensed to do business in Guam; and

WHEREAS, Company is qualified to provide a group health insurance program to GovGuam; and

WHEREAS, GovGuam selected Company to provide group health insurance benefits to GovGuam active and retired employees, their dependents, and survivors of retired employees who receive annuity benefits; and

WHEREAS, Company offers group health insurance program benefits, as hereinafter set forth, under a group health insurance plan known as the "Government of Guam Plan", and

WHEREAS, the parties wish to enter into an agreement defining their mutual rights and obligations.

NOW, THEREFORE, in consideration of the premises, mutual promises and covenants contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

RECEIVED

HSA 2000 Agreement & Certificate

JUN 11 2018

Bureau of Budget and
Management Research

C18064015

CFN-0618-3071

ARTICLE 1

Preamble and Recitals

The preamble and recitals set forth above are hereby incorporated into and made a part of this Agreement.

ARTICLE 2

General Provisions

§2.1 Definitions: The following words and phrases shall have the following meanings, unless a different meaning is required by the context. Words in the singular shall include the plural unless the context indicates otherwise. These are general definitions and are not an indication of the existence of a benefit. The definitions shall control the interpretation of this Agreement, Enrollment forms, any identification cards, any supplements and the performance hereunder, unless the term is otherwise specifically defined or modified within a particular section of this Agreement.

2.1.1 Accident: Shall be defined as an event that is sudden and not foreseen, is exact as to time and place and which results in bodily injury.

2.1.2 Agreement: Shall be defined as this Group Health Insurance Agreement including the Group Health Insurance Certificate and Exhibits A through G.

2.1.3 Ambulatory Surgical Center and/or Surgicenter: Shall be defined as a legally operated institution or facility, either freestanding or part of a Hospital with permanent facilities, which a patient is admitted to and discharged from within a 24-hour period and which:

- 2.1.3.1 has continuous Physician and Nursing services whenever a patient is in the facility; and
- 2.1.3.2 has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; and
- 2.1.3.3 is not a private office or clinic maintained by a Physician for the practice of medicine or dentistry or for the primary purpose of performing terminations of Pregnancy.

2.1.4 Anesthesia Services: Shall be defined as the administration of anesthetics to achieve general or regional anesthesia and related resuscitative procedures.

2.1.5 Birthing Center: Shall be defined as any facility, other than the mother's usual place of residence, that is staffed, equipped and operated for the purpose of providing prenatal care, delivery, immediate postpartum and newborn care rendered within 24 hours after delivery for low risk women and their newborns.

2.1.6 Case Management: Shall be defined as a process directed at coordinating resources and creating flexible, cost-effective options for catastrophically or chronically ill or injured individuals on a case by case basis to facilitate quality individualized treatment goals and improve functional outcomes. Case Management also includes providing any alternative medical or non-medical benefits to a Covered Person that are expected to be medically beneficial for the Covered Person but which may not be Covered Services under this Agreement. Services should be cost-effective and generally follow acceptable standards of evidence based medical practice. The Company may, in its discretion, provide said alternative benefits for a Covered Person's Illness or Injury in lieu of, or in addition to, Covered Services if:

- 2.1.6.1 The total cost of said alternative benefits does not exceed the total benefits payable for Covered Services;
- 2.1.6.2 The Covered Person's Physician recommends that the Covered Person receive said alternative benefits;
- 2.1.6.3 The Covered Person's Physician agrees that the recommended alternative benefits are expected to be beneficial for the treatment of the Illness or Injury; and
- 2.1.6.4 The Covered Person, or the Covered Person's guardian, if the Covered Person is a minor or incapacitated, agrees to receive the alternative benefits.
- 2.1.6.5 The services are prior authorized by the Company's Medical Management Department.

2.1.7 **Certificate:** Shall be defined as the Group Health Insurance Certificate - GovGuam HSA 2000 attached hereto, including the related Exhibits A through G.

2.1.8 **Chemotherapy:** Shall be defined as remedial Services of a euplastic Illness or tumor by means of systemic cytotoxic agents or systemic hormonal agents.

2.1.9 **Chemical Dependency:** The pathological use or abuse of alcohol or other drugs in a manner, or to a degree, that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

2.1.10 **Co-Insurance:** Shall be defined as the percentage of Eligible Charges that a Covered Person must pay for certain Covered Services as stated in this Agreement, and after the Deductible has been met and before the Out of Pocket Maximum has been met. The Out-of-Pocket Maximum provision does not apply to Non-Participating Providers. Subject to the terms of this Agreement, a Covered Person shall be required to pay, as Co-Insurance, the amounts shown on the Schedule of Benefits.

2.1.11 **COBRA:** COBRA, Consolidated Omnibus Budget Reconciliation Act, shall be defined as a federal statute that requires most employers to offer to covered employees and covered dependents who would otherwise lose health coverage for reasons specified in the statute, the opportunity to purchase the same health benefits coverage that the employer provides to its remaining employees. For the purpose of this agreement, the COBRA benefit is not applicable to Government of Guam employees, retirees, and/or dependents.

2.1.12 **Co-Payment:** Shall be defined as the predetermined (flat) dollar amount that a Covered Person must pay for certain Covered Services as stated in this Agreement and after the Deductible, when applicable, has been met.

2.1.13 **Cosmetic Procedure or Surgery:** Shall be defined as Services performed solely for the improvement of a Covered Person's appearance rather than for the improvement, restoration or correction of normal body functions.

2.1.14 **Covered Dependent:** Shall be defined as a Dependent eligible to receive benefits under the terms of this Plan.

2.1.15 **Covered Person:** Shall be defined as a person entitled to receive Covered Services pursuant to the Plan. A Covered Person shall reside in the Service Area and shall be:

- 2.1.15.1 a bona fide employee of GovGuam who is classified as a full time employee by GovGuam; or

2.1.15.2 voluntarily working under the "Quality Time" program and classified as such by GovGuam pursuant to P.L. 25-72; or

2.1.15.3 classified as a retiree of GovGuam by GovGuam; or

2.1.15.4 classified as a survivor of a retired employee of GovGuam by GovGuam; or

2.1.15.5 except as otherwise provided in this Agreement, a Covered Dependent.

2.1.16 Covered Services: Shall be defined as Medically Necessary Services, that are not specifically excluded from coverage by this Agreement and other Services which are specifically included.

2.1.17 Currency: Shall be defined as money accepted as a medium of exchange for payment of debts such as the United States Dollar in the United States and the Peso in the Philippines.

2.1.18 Custodial Care: Shall be defined as Services, whenever furnished and by whatever name called, designed primarily to assist an individual, whether or not totally disabled, in the activities of daily living. These activities include, but are not limited to, Services that constitute personal services such as help in walking, getting in and out of bed, assistance in bathing, dressing, feeding, and Services which do not entail or require the continuing attention of trained medical or paramedical personnel.

2.1.19 Deductible: Shall be defined as the amount paid by a Covered Person or Family for Covered Services during a Plan Year before Covered Services shall be paid by the Company under this Agreement. No deductible shall apply to preventive services as defined by PPACA, routine laboratory and out-patient executive check-up.

2.1.20 Dental Service: Shall be defined as the act of:

2.1.20.1 adjusting, removing, or replacing teeth. The removing of wholly or partly unerupted impacted wisdom teeth shall be considered an oral surgical procedure; or

2.1.20.2 providing Services for teeth, gums, and related parts of the oral cavity; or

2.1.20.3 performing any other Services normally rendered by a Dentist.

2.1.21 Dentist: Dentist means a doctor of medical dentistry or dental surgery who is currently licensed to practice by the appropriate authority of the jurisdiction in which the person practices and who renders Services within the lawful scope of such license.

2.1.22 Dependent: Shall be defined as specified in Article 5 Section 5.2 of the Group Health Insurance Certificate attached hereto.

2.1.23 Domestic Partner: Shall be defined as a person who: (1) is 18 years of age or older; (2) is of the same or opposite sex as the Subscriber; (3) is in an exclusive mutually committed relationship with the Subscriber and intends to remain the Subscriber's sole domestic partner; (4) is not married to any other person; (4) is not related to the Subscriber by blood to a degree that would prohibit marriage; and (5) has cohabitated with the Subscriber for the two (2) consecutive years immediately preceding the proposed Enrollment.

2.1.24 Domicile: Shall be defined as the place where a person has his or her true, fixed, and permanent home and principal establishment, and to which whenever that person is absent that person has the intention of returning. A person shall have only one domicile at a time.

2.1.25 Durable Medical Equipment: Shall be defined as equipment which is:

- 2.1.25.1 Able to withstand repeated use; and
- 2.1.25.2 Primarily and customarily used to serve an Illness or Injury; and
- 2.1.25.3 Not generally useful for a person in the absence of Illness or Injury.

2.1.26 Eligible Charge(s): Shall be defined as the portion of charges made to a Covered Person for Covered Services rendered which are payable to the Provider under this Agreement. For a Participating Provider, the Eligible Charges shall be the reimbursement amounts agreed to between the Company and the Participating Provider.

For a Non-Participating Provider, the Eligible Charges for covered medical Services rendered by a provider who is not a Participating Provider, shall be limited to the lesser of (a) the actual charge made by the provider, or (b) in the United States, the Medicare Participating Provider fees in the geographic area where the Service was rendered; or (c) in Asia, the lesser of the amounts billed or the fees most recently contracted by the Company at St. Luke's Medical Center, Manila, Philippines, or (d) elsewhere, the Medicare National Standard Fee.

For a Non-Participating Provider, the Eligible Charges for covered dental Services shall be the lesser of (a) the actual charges made by the provider or (b) the usual customary and reasonable charge, as determined by the Company, for the dental Service in the geographic region in which that Service was rendered.

2.1.27 Emergency:

- 2.1.27.1 In general, an Emergency shall be defined as an Accidental Injury or an acute or serious medical condition of sudden or unexpected onset requiring immediate medical attention because any delay in treatment, in the opinion of the Physician, would seriously impair future treatment or result in permanent disability, a serious worsening of the condition, or irreparable harm to the Covered Person's health or endanger his or her life. Examples of Emergencies include, but are not limited to heart attack, severe hemorrhaging, loss of consciousness, convulsions and loss of respiration.
- 2.1.27.2 For purposes of compliance with the requirements of Section 2719A(b) of the PHSA, as added by PPACA, a PPACA Emergency shall mean an injury or medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to place the health of an individual (including the health of a pregnant woman or her unborn child) in serious jeopardy, or to result in serious impairment to bodily functions or serious dysfunction of any bodily organ or part.
- 2.1.27.3 PPACA Emergency Services shall mean services provided by the emergency department of a Hospital, including a medical screening examination, and also including ancillary services routinely available to the emergency department to evaluate such condition, and such further medical examination and treatment to stabilize the Covered Person as are within the capabilities of the staff and facilities available at the hospital.
- 2.1.27.4 Co-Insurance percentages and Co-Payment amounts for any PPACA Emergency Services provided by Non-Participating Providers shall not be greater than such percentages or amounts that would be applied to Participating Providers. The

Company's payments for any PPACA Emergency Service shall not be more than the greater of:

- 2.1.27.4.1 The amount negotiated with Participating Providers for the PPACA Emergency Service (excluding any Co-Insurance or Co-Payment normally charged the Covered Person for such service when provided by Participating Providers); or
- 2.1.27.4.2 The amount calculated using the same method the Company generally uses under this Agreement to determine payments for such services when provided by Non-Participating Providers, but excluding any Co-Insurance or Co-Payment normally charged the Covered Person for such service when provided by Participating Providers; or
- 2.1.27.4.3 The amount that would be paid under Medicare (Part A or Part B) for the PPACA Emergency service, excluding any Co-Insurance or Co-Payment normally charged the Covered Person for such service when provided by Participating Providers.

2.1.28 Enrollment: Shall be defined as the acceptance, as of a specified date, of a written application for coverage under the Plan on forms provided by the Company.

2.1.29 Experimental: Shall be defined as all procedures and treatments not covered under the Medicare Program (Title XVIII of Social Security Act of 1965, as amended), unless otherwise specifically included or excluded under this Agreement.

2.1.30 Family: Shall be defined as a Subscriber and his or her Covered Dependents.

2.1.31 HIPAA: Shall be defined as the Health Insurance Portability and Accountability Act of 1996, as amended (including amendments by PPACA), including all provisions codified at 42 U.S.C. §300gg, and the regulations promulgated thereunder.

2.1.32 Home Health Care: Shall be defined as the Services set forth below, subject to all other exclusions and limitations set forth in this Agreement:

- 2.1.32.1 Part-time or intermittent home nursing Services from or supervised by a registered Nurse or a licensed practical Nurse;
- 2.1.32.2 Part-time or intermittent home health aide Services;
- 2.1.32.3 Physical therapy; and
- 2.1.32.4 Medical supplies, drugs and medications prescribed by a Physician, and laboratory Services to the extent that they would have been covered if provided or performed in a Hospital or Skilled Nursing Facility.
- 2.1.32.5 To be a Covered Service, Home Health Services shall:
 - 2.1.32.5.1 replace a needed Hospital or Skilled Nursing Facility stay.
 - 2.1.32.5.2 be for the care or treatment of a Covered Person's Illness or Injury.

2.1.32.5.3 be ordered in writing by the Covered Person's Physician; and

2.1.32.5.4 be provided in the Covered Person's home (permanent or temporary) by a properly licensed Home Health Care Agency.

2.1.33 Home Health Care Agency: Shall be defined as a public or private agency or organization, or part of one, that primarily provides Home Health Care Services and complies with the following requirements

2.1.33.1 Is legally qualified in the state or locality in which it operates;

2.1.33.2 Keeps clinical records on all patients;

2.1.33.3 Services are supervised by a Physician or Nurse; and

2.1.33.4 Services provided by the Home Health Care Agency are based on policies established by associated professionals, which include at least one Physician and one Nurse.

2.1.34 Home Health Care Plan: Shall be defined as a program of Home Health Care established and approved in writing by the Covered Person's Physician for the provision of Home Health Care Services. The Physician shall state that confinement to a Hospital or Skilled Nursing Facility would be Medically Necessary for the treatment of the Covered Person's Injury or Illness if the Home Health Care Plan is not provided.

2.1.35 Hospice: Shall be defined as a coordinated plan of home and/or Inpatient Services, which treats a Terminally Ill patient and his or her family as a unit, focusing on providing comfort rather than on curing an illness. The plan provides Services to meet the special needs of the family unit during the final stages of a Terminal Illness and during bereavement. These services may include physical care, counseling, drugs, equipment and supplies for the terminal illness and related condition(s). Services are provided by a team made up of trained medical personnel, homemakers and counselors. The team acts under an independent hospice administration and helps the family unit cope with physical, psychological, spiritual, social and economic stress. Hospice is generally provided in the home, is not limited to people with cancer, and must be approved as meeting established standards, including but not limited to compliance with any licensing requirements of Guam, and the benefit period begins on the date the attending physician certifies that a covered member is terminally ill.

2.1.36 Hospital: Shall be defined as a medical institution which is operated in accordance with the laws of the jurisdiction in which the Hospital is located. The Hospital must, on an Inpatient basis, be primarily engaged in providing diagnostic and therapeutic facilities for surgical and medical diagnosis, and treatment of injured and sick persons. These Services must be provided by or under the supervision of Physicians and the institution must continuously provide twenty-four (24) hours a day Nursing Service by Nurses.

2.1.36.1 A Hospital may include a psychiatric or tuberculosis facility which satisfies the above requirements.

2.1.36.2 Any institution which is, primarily, a place for rest, a place for the aged, or a nursing home shall not be considered a Hospital for purposes of this Agreement.

2.1.37 Injury: Shall be defined as a condition caused by Accidental means that results in damage to the Covered Person's body independently of Illness and is a result of an unexpected slip, fall, blow or other violent external force. Injury shall also include a scenario that is not unexpected or not Accidental if it constitutes a PPACA Emergency.

2.1.38 Illness: Shall be defined as a bodily disorder, disease, physical sickness, Pregnancy, Mental or Nervous Condition or congenital abnormality.

2.1.39 Inhalation Therapy: Shall be defined as remedial Services for an Illness or Injury by means of intermittent positive pressure breathing equipment.

2.1.40 Inpatient: Shall be defined as a Covered Person admitted to a Hospital, Skilled Nursing Facility or Hospice for a condition requiring confinement.

2.1.41 Intensive Care Unit: Shall be defined as a section, unit or area of a Hospital that is designated as an intensive care unit by the Hospital and is reserved and operated exclusively for the purpose of providing Services for critically ill patients.

2.1.42 Maximum Annual Benefit: Shall be defined as those benefits payable under this Agreement that have annual maximum limits for each Covered Person as shown in Exhibit A and B.

2.1.43 Medically Necessary or Medical Necessity: Shall mean services or supplies which, under the provisions of this Agreement, are determined to be:

- 2.1.43.1 appropriate and necessary for the symptoms, diagnosis or treatment of the Injury or Illness or dental condition;
- 2.1.43.2 provided for the diagnosis or direct care and treatment of the Injury or Illness or dental condition;
- 2.1.43.3 within standards of good medical or dental practice within the organized medical or dental community;
- 2.1.43.4 not primarily for the convenience of the Covered Person or of any Provider providing Covered Services to the Covered Person;
- 2.1.43.5 an appropriate supply or level of service needed to provide safe and adequate care;
- 2.1.43.6 within the scope of the medical or dental specialty, education and training of the Provider;
- 2.1.43.7 provided in a setting consistent with the required level of care; or
- 2.1.43.8 preventative Services as provided in the Plan.

2.1.44 Medicare: Shall be defined as Title XVIII (Health Insurance for the Aged) of the Federal Social Security Act, which includes Part A, Hospital Insurance Benefits for the Aged; Part B, Supplementary Medical Insurance Benefits for the Aged; and Part C, miscellaneous provisions regarding both programs, and also including any subsequent changes or additions to those programs.

2.1.45 Mental or Nervous Condition: Shall be defined as a condition which includes neurosis, psychoneurosis, psychopathy, or psychosis or disease of any kind, in a degree which subsequently impairs the Covered Person's economic or social functioning; and shall, as required by the Parity In Health Insurance For Mental Illness and Chemical Dependency Act, Title 22, Guam Code Annotated, Chapter 28, include the definition of Mental Illness contained in said Act; and shall include, as required, relevant definitions found in the Mental Health Parity Act of 1996, Public Law 104-204.

2.1.46 Military Service: Shall be defined as service for any length of time in any branch of the Armed Forces or Merchant Marine of any country, combination of countries, or international organizations, except temporary training service for two months or less.

2.1.47 Newborn: Shall be defined as an infant during the period beginning on the date of birth until the initial Hospital discharge or until the infant is thirty (30) days old, whichever occurs first.

2.1.48 Non-Participating Provider Eligible Charges: Eligible Charges for covered medical Services rendered by a provider who is not a Participating Provider, shall be limited to the lesser of (a) the actual charge made by the provider, or (b) whichever of the following is applicable: (i) in the United States, the Medicare participating provider fee schedule in the geographical area where the service was rendered, or (ii) in Asia, the lesser of the amounts billed or the fees most recently contracted by the Company at St. Luke's Medical Center, Manila, Philippines, or (c) elsewhere, the Medicare national standard fee schedule.

2.1.49 Nurse, Nursing, Nursing Services: Shall be defined as a registered graduate nurse (RN), a licensed vocational nurse (LVN), or licensed practical nurse (LPN) who has received specialized Nursing training and experience and is duly licensed to perform such Nursing Services by the state or regulatory agency responsible for such licensing in the jurisdiction in which the individual performs such Services.

2.1.50 Occupational Injury: Shall be defined as an Injury arising out of, or in the course of, employment.

2.1.51 Organ Transplant: Shall be defined as the replacement of a diseased organ with a healthy organ from a donor with a compatible issue type.

2.1.52 Other Plan: Shall be defined as any other health insurance or health benefits program offered to GovGuam's employees, retirees and their eligible Dependents, through an Agreement with GovGuam.

2.1.53 Out of Pocket Maximum: Shall be defined as the total maximum of any Eligible Charges paid, or payable as defined by a payment schedule or arrangement by a Covered Person to a Participating Provider to satisfy any applicable Deductible, Co-Payment, and/or Co-Insurance specified in this Agreement before the Plan will begin to pay Covered Services at one hundred percent (100%) for the remainder of the Plan Year, subject to the maximum amounts provided in the Plan as indicated in Exhibit A.

2.1.54 Palliation Therapy: Shall be defined as patient and family centered care that optimizes the quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs and facilitating patient autonomy, access to information and choice. Palliative care should be covered on an outpatient basis only.

2.1.55 Participating Providers, Non-Participating Providers, Providers and Network:

2.1.55.1 "Providers" shall be defined as health care providers who are duly licensed in their jurisdiction and acting within the scope of their license. Such term shall include, without limitation, Physicians, Hospitals, ancillary health Services facilities and ancillary health care providers.

2.1.55.2 "Participating Providers" shall be defined as Providers who: (i) have directly, or indirectly through Company's agreements with other networks, entered into an agreement with the Company to provide the Covered Services; and (ii) are assigned from time to time by the Company to participate in the Network or any other network of Company pursuant to this Agreement.

- 2.1.55.3 "Network" shall be defined as the network of Participating Providers. Network may also be referred to as "Plan Network".
- 2.1.55.4 "Non-Participating Provider" shall be defined as Providers who have NOT been contracted by the Company to provide medical or dental services to Covered Persons.
- 2.1.55.5 Payment of claims to Providers: Claims shall be paid based on the agreements that Company has with its providers whenever the services are rendered by a participating provider; and based on the Usual, Customary, and Reasonable whenever the services are rendered by a non-participating provider.

2.1.56 **PHSA:** Shall mean the Public Health Service Act provisions that are part of HIPAA (as defined above), some of which have been added to the PHSA by PPACA.

2.1.57 **Physician:** Shall be defined as a legally licensed medical doctor, Dentist, surgeon, chiropractor, osteopath, podiatrist (chiropracist), optometrist, or clinical Psychologist acting within the scope of his or her license. A Physician shall not include a medical resident, intern, fellow, Physician's assistant, social worker or master prepared therapist.

2.1.58 **Physician's Services:** Shall be defined as Medically Necessary professional Services provided by duly licensed Physicians including diagnosis, consultation, medical treatment, surgery, anesthesia, physical therapy, x-ray and laboratory services, diagnostic procedures such as electrocardiograms, electroencephalograms, and other services customarily provided by Physicians for patients. Experimental Services shall not be included within the scope of Physicians' Services.

2.1.58.1 **Primary Care Services.** Basic, routine or general health care services of individuals with common health problems and chronic illnesses that can be managed on an outpatient basis. Primary care is provided by primary care physicians, nurse practitioners, physician assistants and other mid-level practitioners.

2.1.58.2 **Specialist Care Services.** Services provided by a medical specialist to whom a patient has been referred, usually by a primary care provider.

2.1.59 **Physical Therapy:** Shall be defined as remedial Services for the treatment of an Injury or Illness by means of therapeutic massage and exercise; heat, light and sound waves; electrical stimulation; hydrotherapy; and manual traction.

2.1.60 **Plan:** Shall be defined as the group health insurance benefits provided in accordance with this Agreement.

2.1.61 **Plan Year:** Shall be defined as the twelve (12) month period during which group health insurance benefits are provided under this Agreement.

2.1.62 **PPACA:** Shall mean the Patient Protection and Affordable Care Act of 2010, as amended.

2.1.63 **PPACA Preventative Care Services:** Shall mean care required by Section 2713 of the PHSA, as added by PPACA, to be provided without cost-sharing.

2.1.63.1 Care considered PPACA Preventative Care shall be:

- 2.1.63.1.1 Evidence-based items or services that have in effect a rating of A or B in the most recently updated recommendations of the United States Preventive Services Task Force ("USPSTF") with respect to the individual involved, except that 2009 USPSTF recommendations regarding breast cancer screening, mammography, and prevention issued in or around November 2009 shall not be considered current for purposes of this provision; and
- 2.1.63.1.2 Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
- 2.1.63.1.3 With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and
- 2.1.63.1.4 With respect to women, any additional evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.
- 2.1.63.2 No Co-Payments, Co-Insurance or Deductibles shall be imposed on Covered Persons for PPACA Preventive Care Services. If Participating Provider billing data for office visits bill or track PPACA Preventive Care Services separately from other services or items provided at an office visit, Co-Payments, Co-Insurance and Deductibles shall apply (unless otherwise provided under this Agreement) to all services that are not PPACA Preventive Care Services. If PPACA Preventive Care Services are not billed or tracked separately, the entire office visit shall be treated as a PPACA Preventive Care Services visit if PPACA Preventive Care was the primary purpose of such visit, but otherwise the entire office visit shall (unless otherwise provided under this Agreement) be treated as not being a PPACA Preventive Care Service,
- 2.1.63.3 Except as specifically provided in this Agreement, PPACA Preventive Care Services shall only be provided without Deductibles, Co-Insurance or Co-Payments if provided by Participating Providers.

2.1.64 **Preferred Drug Formulary:** Shall be defined as those medications chosen by the Company for their safety, effectiveness and affordability. The Preferred Drug Formulary is subject to change during the Plan Year.

2.1.65 **Pregnancy:** Shall be defined as the physical state which results in childbirth, abortion or miscarriage and any medical complications arising out of or resulting from such state.

2.1.66 **Premium:** Shall be defined as the dollar amount paid to the Company for the provision of this Plan to Covered Persons, including any contributions required from the Covered Persons.

2.1.67 **Preferred Provider(s):** Preferred Provider shall be defined as a Participating Provider that is a Hospital or Ambulatory Surgical Center located outside of the Service Area. The Hospital or Ambulatory Surgical Center shall be specifically designated by name as Preferred Provider at the time Services are rendered to the Covered Person and shall be specifically designated by name as Preferred Provider in the more recent of Company's most current member brochure or Company's most current updated listing of Preferred Providers.

2.1.68 Psychiatric Services or Psychoanalytical Care: Shall be defined as Services provided for the treatment of a Mental or Nervous Condition.

2.1.69 Psychologist: Shall be defined as an individual holding the degree of Ph.D., licensed as a psychologist in the jurisdiction in which services are provided, and acting within the scope of his or her license.

2.1.70 Registered Bed Patient: Shall be defined as a Covered Person who has been admitted to a Hospital or a Skilled Nursing Facility or a Hospice upon the recommendation of a Physician for any Injury or Illness covered by this Agreement and who is confined by the Hospital, Skilled Nursing Facility or Hospice as an Inpatient.

2.1.71 Room and Board: Shall be defined as all charges, by whatever name called, which are made by a Hospital, Hospice, or Skilled Nursing Facility as a condition of providing Inpatient Services. Such charges do not include the professional Services of Physicians nor intensive, private duty Nursing Services by whatever name called.

2.1.72 Semi-Private: Shall be defined as a class of accommodations in a Hospital or Skilled Nursing Facility in which at least two (2) patient beds are available per room.

2.1.73 Services: Shall be defined as medical, dental or other health care services, treatments, supplies, medications and equipment.

2.1.74 Service Area: Shall be defined as Guam and the Commonwealth of the Northern Mariana Islands. Enrollment to this Plan is limited to individuals residing in the Service Area. However, residence in the service area shall not be a requirement for enrollment for dependent children below 26 years of age.

2.1.75 Skilled Nursing Facility: Shall be defined as a specially qualified and licensed facility that:

- 2.1.75.1 For a fee and on an Inpatient basis, provides 24 hour per day skilled Nursing services under the full-time supervision of a Physician or Nurse and provides physical restoration services for persons convalescing from an Injury or Illness; and
- 2.1.75.2 maintains daily clinical records; and
- 2.1.75.3 complies with legal requirements applicable to the operation of a skilled nursing institution; and
- 2.1.75.4 has transfer arrangements with one or more Hospitals; and
- 2.1.75.5 has an effective utilization review plan; and
- 2.1.75.6 is approved and licensed by the jurisdiction in which it operates.

2.1.76 Specialty Drugs: Charges for medications used to treat certain complex and rare medical conditions. Specialty drugs are often self-injected or self-administered. Many grow out of biotech research and may require refrigeration or special handling.

2.1.77 Spouse: The Spouse of the Subscriber includes: (i) lawful wedded husband or wife; (ii) a domestic partner as defined in 2.1.24 or (iii) a divorced spouse where there is an order issued by a court having jurisdiction over the parties that the Subscriber continue to provide such spouse coverage under the Plan, provided that no Subscriber can enroll more than one (1) person as a spouse at a time unless one spouse is covered pursuant to a court order.

2.1.78 Subscriber: Shall be defined as a Covered Person who is not a Dependent.

2.1.79 Surgery and Surgical Services: Shall be defined as Medically Necessary Services directly performed by a Physician in the treatment of an Injury or Illness which requires one or more of the following: cutting; suturing; diagnostic or therapeutic endoscopic procedures; debridement of wounds, including burns; surgical management or reduction of fractures or dislocation; orthopedic casting; manipulation of joints under general anesthesia; or destruction of localized lesions, cryotherapy or electrosurgery. The term "Surgery" does not include Dental Services, routine venipuncture or minor endoscopic examinations.

2.1.80 Terminally Ill: Shall be defined as a medical prognosis of limited expected survival of six (6) months or less at the time of referral to a Hospice of a Covered Person with a chronic, progressive Illness which has been designated by the Covered Person's attending Physician as incurable.

2.1.81 Urgent Care: Shall be defined as the delivery of ambulatory medical care outside of a hospital emergency department on a walk-in basis, without a scheduled appointment. Urgent care centers treat many problems that can be seen in a primary care physician's office, but urgent care centers offer some services that are generally not available in primary care physician's offices such as x-rays and minor trauma treatment.

2.1.82 Well Child Care: Shall be defined as Services rendered to a Dependent Child from newborn to seventeen (17) years of age solely for the purpose of health maintenance and not for the Treatment of an Illness or Injury.

§2.2 PPACA Requirements: It is the intent of this Agreement to provide, at a minimum, all of the benefits, rights and responsibilities afforded as a result of the Patient Protection and Affordable Care Act (Public Law 111-148), and the regulations promulgated under the authority of this Act, except for the benefits, rights and responsibilities as specifically excluded by GovGuam.

§2.3 Guaranteed Renewability of Health Insurance Coverage: In the event that GovGuam invokes the protection afforded by the Health Insurance Portability and Accountability Act of 1996, as amended, found at Section 2712 of the Public Health Services Act, and its regulations, for the guaranteed renewability of health insurance coverage the parties agree that coverage would be continued until a new contract is in place with the first ninety (90) days of coverage guaranteed at the same rate and plan designs.

ARTICLE 3

Services

§3.1 Company shall provide Covered Persons with the group health insurance benefits, subject to the applicable limitations and conditions, set forth in this Agreement and the Certificate incorporated herein.

ARTICLE 4

Rates, Premiums and Experience Participation

§4.1 Rates. Company shall provide the group health insurance benefits set forth in the Certificate for the rates contained herein.

§4.2 Premium Payment. GovGuam shall pay the Premium due under this Agreement to Company within fifteen (15) business days after the close of each GovGuam pay period. Each such Premium payment shall be for the preceding pay period. Payment in full of all Premiums due constitutes a discharge of GovGuam's responsibility for the cost of benefits and administration provided under this Agreement. Should GovGuam fail to pay any Premium when due under this Agreement, Company shall have the right to suspend performance under this Agreement with respect to any Covered Person whose Premium payments have not been paid by GovGuam, in addition to the right of termination under Article 5.2.1 and Article 5.3. However, such suspension may only take place after Company provides written notice to GovGuam at least ten (10) days

prior to the suspension stating the names of the Covered Persons at risk of suspension and the amount of Premium owed for each. Further, Company shall retroactively reinstate a Covered Person's right to benefits upon full payment of the past due Premiums only if the premiums are paid within 120 days after the notification of the suspension.

§4.3 Experience Participation. No later than January 31, 2019, the Company shall present to GovGuam an annual experience participation accounting, which will produce either a positive or negative balance after accounting for all incurred claims and the 14% of premium guaranteed retention for the Company, such experience participation to be determined as follows,

4.3.1 The term "Target Experience" shall mean the amount calculated by multiplying (a) the total Premiums earned by the Company for the full 12-month Plan Year ending September 30, 2018 under the HSA \$2,000 deductible policy and the PPO \$1,500 deductible policy issued to GovGuam with respect to such Plan Year (such two separate policies being referred to, collectively, as the "Participating Policies"), by (b) eighty-six percent (86%).

4.3.2 The "Actual Experience" shall be an amount calculated by subtracting from the Target Experience all claims incurred during such Plan Year under both the Participating Policies (i.e., Actual Experience = Target Experience (Total Premiums x 86%) minus incurred claims, the PPACA Insurance Company Fee or Tax and the PCORI fee).

4.3.3 To the extent the Actual Experience is positive (i.e., an amount greater than zero), such amount will be called an "Experience Refund," and the Company shall remit such amount to GovGuam for placement into the "Section 2718 Fund" established by Title 4, Guam Code Annotated, Section 4302.3 (P.L. 31-233:XII:18).

4.3.4 To the extent the Actual Experience is negative (i.e., an amount less than zero), the Company may add this amount to the premium needed for the Plan Year beginning on October 1, 2018, but only if the Company is the health insurance provider during such Plan Year.

4.3.5 This Experience Participation provision determines the combined Actual Experience of both the Participating Policies. Identical provisions, describing the combined calculation, are included in each of the Participating Policies for convenience, but the result of the combined calculation shall be applied only once. If necessary to determine the distribution of any positive or negative amount of Actual Experience between the two Participating Policies, such amount may be allocated between the two policies in any share, at the discretion of GovGuam, as long as the total of the shares is equal to the combined amount of the Actual Experience.

4.3.6 If PPACA's Minimum Loss Ratio ("MLR") requirements result in payment, from the Company to GovGuam, of a refund for either the 2016 or 2017 calendar year MLR calculations, any Experience Refund calculated above in section 4.3.3, will be reduced by the portion of the MLR refund payable to GovGuam and applicable to the Participating Policies. The portion applicable to the Participating Policies is determined by multiplying the MLR refund by the ratio of the Participating Policies' earned premium in the calendar year to the total of the GovGuam earned premium in that calendar year. A hypothetical illustration is included in this agreement as Exhibit G.

ARTICLE 5

Term and Termination

§5.1 Term. The Agreement is for a one year term beginning October 1, 2016 and ending September 30, 2017, unless terminated for major default in services, given by written notice from GovGuam to Company not less than ninety (90) calendar days or unless modified by mutual agreement.

§5.2 Termination.

5.2.1 By Company. If GovGuam fails to make any Premium payment within fifteen (15) days after receipt of a written notice of non-payment from Company, Company may terminate this Agreement by providing at least fifteen (15) days prior written notice of termination to GovGuam and all Subscribers under this Agreement.

§5.3 Individual termination.

5.3.1 Non-payment of Premium. Company may, in accordance with the notice provisions contained in §5.2.1, terminate the coverage of one or more individual Covered Persons for non-payment of Premium without terminating this Agreement as to other Covered Persons for whom Premiums have been received by Company.

5.3.2 Other Reasons. Except for non-payment of Premiums, Company may only terminate a Covered Person as provided in Article 5 of the Group Health Insurance Certificate attached hereto.

5.3.3 Review of Termination. Any Covered Person whose coverage is terminated pursuant to this Section 5.3 shall be entitled to a review through the PPACA Claims Procedure set forth in this Agreement, if so requested.

§5.4 Effect of Termination. In the event of termination of this Agreement for a Covered Person, Company shall be responsible for providing the benefits contained in this Agreement up to the effective date of termination and GovGuam shall be responsible for payment of the Premiums up to said effective date.

5.4.1 Termination of Subscriber's Coverage. If a Subscriber's coverage terminates, the coverage of all of that Subscriber's Covered Dependents also terminates as of the same date.

ARTICLE 6

Enrollment

§6.1 Regular Open Enrollment. The parties to this Agreement shall establish one (1) open Enrollment period, which shall be the same period as for all Other Plans offering health insurance and/or health benefits programs to GovGuam. During such period GovGuam shall provide Company with the assistance and cooperation detailed in Article 8. Except as provided in §6.1.1, §6.2 and §6.3 below, the open Enrollment period is the only time during which current and potential Covered Persons shall be allowed to enroll in this Plan or to disenroll from this Plan. The effective date of such Enrollment or disenrollment shall be the effective date of this Agreement, unless otherwise specified by GovGuam in accordance with this Agreement, or unless otherwise required under HIPAA.

6.1.1 Special Open Enrollments. If GovGuam holds a special open Enrollment during the Plan Year, Company shall participate in such special open Enrollment, unless otherwise agreed by the parties, or unless the Plan is no longer to be offered as of the entry date of the special open Enrollment period. If the special open Enrollment shall impact on rates, the parties shall negotiate an appropriate change prior to the participation of Company in such special open Enrollment.

§6.2 Newly Eligible Persons. Subject to §6.3, any individual who becomes a GovGuam employee, or for any other reason first becomes eligible to be a Covered Person outside the open Enrollment period, shall have thirty (30) days after the date on which he/she became eligible to become a Covered Person. The effective date of such Enrollment shall be as specified in §5.7 of the Certificate.

§6.3 Otherwise Eligible. Enrollment shall be restricted to only those occasions provided for in this Article 6 unless an individual is eligible for Enrollment under the HIPAA provisions allowing special enrollment rights. Enrollment shall be in accordance with HIPAA and PPACA requirements.

§6.4 Disenrollment Permitted. Covered persons for whom this group health insurance is secondary to Medicare coverage, shall be permitted to disenroll with 30 days notice to the company, and enroll in the Retiree Supplemental Plan.

ARTICLE 7

Company's Responsibilities

§7.1 Marketing. Company shall print and provide necessary brochures, announcements, instructions, Enrollment forms, and certificates for Enrollment purposes and for distribution to potential Covered Persons. Company shall be responsible for the dissemination of information to potential Covered Persons regarding the Plan. Company shall provide agreed upon quarterly communication to members clearly defining the benefits of the current plans in place. Company will work directly with the Government of Guam to determine their needs in distribution, and type of communication desired.

§7.2 Benefits to be Provided. Company shall, in consideration of receipt of applicable Premiums, provide the benefits contained in this Agreement through the earlier of the effective date of a Covered Person's termination or the termination of this Agreement.

§7.3 Financial and Medical Cost Information. In accordance with Title 4 GCA, Section 4302 (b) and (g), Company shall provide GovGuam detailed claims utilization and cost information, and shall provide upon reasonable request, the most recent audited financial statements, experience data, and any other information pertaining to this Agreement. GovGuam may, upon reasonable notice of no less than fifteen (15) working days, audit Company to confirm the accuracy of the information provided specifically to the government of Guam book of business.

§7.4 Confidential Information. The parties hereto shall maintain the confidentiality of any and all medical records which shall be in their possession and control, and such information shall only be released or disseminated pursuant to the valid authorization of the Covered Person whose medical condition is reflected in such medical records or as shall be otherwise permitted under applicable law. Upon request and subject to applicable law, Company shall make available to GovGuam medical records to assure Covered Persons are receiving adequate and appropriate benefits in accordance with the Certificate.

§7.5 Errors and Omission Insurance. The Company shall use all reasonable efforts to secure and maintain current errors and omission liability insurance of at least One Million Dollars (\$1,000,000) during the term of this Agreement.

§7.6 Payment of Claims. Company shall pay claims in accordance with the Guam Health Care Prompt Payment Act of 2000 and the applicable claims payment requirements of PPACA. Appeals of claim denials shall comply with applicable requirements of PPACA Section 2719 and regulations thereto on internal claims appeal process and external appeals process review requirements.

§7.7 Prompt Payment Report. Company shall send a status report on a claim filed by Covered Person against a Provider within forty-five (45) days after receipt if the claim is still pending disposition by the Company and Provider. . At a minimum the report shall indicate that the claim is under review and the Company is working to resolve the claim with the Provider. The Company shall send another status report on the claim to the Covered Person with a copy to the Provider thirty (30) days from the date the first status report was sent to the Covered Person if the claim has not been resolved.

§7.8 Notification. Company shall fulfill the notice requirements of the Women's Health and Cancer Rights Act of 1998, and the Newborns' and Mothers' Health Protection Act of 1996, and shall be responsible for notice requirements applicable to PPACA requirements.

§7.9 **Termination Notification.** If the Company terminates this Agreement, Company shall provide GovGuam with an adequate number of payroll staffers announcing its termination at least fifteen (15) days prior to the date of termination. Further, Company shall fully cooperate with GovGuam in transitioning Covered Persons to Other Plans.

§7.10 **Sole Source Provider.** If there is a Covered Service which is provided on Guam by only one provider who is not a Participating Provider, the eligible Charges for such services shall be as if the sole source provider were a participating provider.

§7.11 **Performance Guarantees.** Performance guarantees have the appropriate annual penalties listed by each guarantee as stated in Exhibit E with a maximum amount of \$105,000 annually. The penalties, if any, are to be paid annually upon an annual review meeting within thirty (30) days after the end of the plan year, and they are combined for the PPO1500 and HSA2000 Agreement.

§7.12 **Online Access Capabilities.** The Company shall provide, for the benefit of the Covered Person and GovGuam, the following online access capabilities:

7.12.1 Online access is available twenty-four (24) hours a day, seven (7) days a week in accordance with Section 508 standards of the Rehabilitation Act of 1973 as amended.

7.12.2 For the Covered Person, access to Personal Claim Record ("PCR") to include historical health conditions, prescription medications, office visit summary and procedures where a medical claim has been filed.

7.12.3 For the Covered Person, access to record of medical and drug claims.

7.12.4 For the Covered Person, ability to verify eligibility.

7.12.5 Ability of Providers to submit claims electronically for payment.

7.12.6 For the Covered Person, GovGuam, and Providers access to Schedule of Benefits, Member Handbooks and Provider Network Information.

7.12.7 For the Covered Person, ability to export PCR to federal compliance standard file formats or plain text file.

7.12.8 For the Covered Person, ability to print online membership cards.

7.12.9 For the Covered Person, access to interactive tools for researching health issues, treatments, and risk assessment tools for health conditions.

ARTICLE 8

GovGuam's Responsibilities

§8.1 **Marketing.** GovGuam shall give Company reasonable assistance and cooperation to enable Company to contact all sources of Enrollment, to disseminate all information, to distribute and post literature, to provide access to employees during working hours, to provide all employees' names and addresses, and to instruct department heads to provide Company's representatives reasonable opportunity for personal contact with employees, consistent with that given other GovGuam contracted health plans, for the purpose of explaining Company's Plan to GovGuam employees.

§8.2 **Responsible Persons.** GovGuam shall designate persons within each agency, department and branch, who shall be responsible for the handling of health insurance problems, Enrollment, and cancellations within their particular

department. These designated persons shall be available to attend meetings on government time for the purpose of reviewing administrative procedures, and to assist in problem solving relating to this Agreement.

§8.3 Personnel Changes. GovGuam shall provide written notice to Company of terminations, resignations, department transfers, and the like, so that coverage can be terminated at the appropriate time. GovGuam shall make available to Company a computer listing of each employee receiving an applicable payroll deduction for Premiums no later than fifteen (15) working days following each pay period.

8.3.1 Individual with Questionable Status. If GovGuam does not provide the list of employees as required in §8.3, Company shall have the right to charge an individual whose Enrollment is in question for any Covered Services rendered prior to receipt of written verification of eligibility and Enrollment by GovGuam. If such individual is subsequently determined to be a Covered Person, and GovGuam remits a Premium payment for the Covered Person for the period for which the Covered Services were rendered, Company shall cancel all charges to the Covered Person and return any amounts collected. If Company files a written objection to an Enrollment list forwarded by GovGuam, then within thirty (30) days after the filing, GovGuam shall provide Company with the applicable change of status forms, Enrollment cards, and other documentation substantiating the accuracy of the Enrollment records and meet with Company to reconcile any differences. Evaluation of such individual's entitlement shall be handled in accordance with PPACA's applicable Claims Procedure requirements, taking into account any applicable PPACA prohibition on rescissions and any applicable PPACA requirement that costs of care be provided or continued during evaluation period

§8.4 No restrictions on Enrollment. GovGuam shall place no restriction or limitation on the percentage or number of Enrollments in the Plan.

ARTICLE 9

Covered Person's Responsibilities

§9.1 Acceptance. By Enrolling in the Plan, all Covered Persons agree to the terms, provisions and conditions of this Agreement.

§9.2 Continued Residency. Except as specifically stated in this Agreement, Enrollment in the Plan shall be limited to Covered Persons domiciled in the Service Area, and who do not reside outside the service area for more than one hundred eighty-two (182) days per plan year, Company shall be entitled to require substantiation from a Covered Person to determine the Covered Person's Domicile and may deny benefits under this Agreement for lack thereof. For a Covered Person Domiciled in the Service Area, time spent receiving continuous medical Services out of the Service Area shall not count toward the one hundred eighty-two (182) day maximum, provided the receipt of such Services precludes returning to the Service Area. Further, time spent by a parent or Spouse of such covered person shall not count toward the one hundred eighty-two (182) day maximum, provided the parent or Spouse is providing necessary assistance to the Covered Person and further provided that under no circumstance can there be more than one such caregiver hereunder for any incident of care out of the Service Area.

ARTICLE 10

Notices

§10.1 Address of Record. For the purpose of communication and services of notice under this Agreement, the parties' addresses are as follows:

To: TakeCare Insurance Company, Inc.
415 Chalan San Antonio, Ste. 108
Tamuning, Guam 96913

To: GovGuam
Director
Department of Administration

Government of Guam
590 S Marine Corps Dr., Ste. 224
Tamuning, Guam 96913

§10.2 Method of Service. Notices shall be in writing and effective upon either receipt of a hand-delivered notice or the posting of notice by first class mail, postage prepaid, to the address listed herein or such other address as a party may designate by providing written notice to the other party from time to time.

ARTICLE 11

Dispute Resolution

§11.1 Mandatory Disputes Resolution Clause (As amended but consistent with 2 GAR Div. 4 § 9103(g) and applicable law). GovGuam and the Company agree to attempt resolution of all controversies which arise under, or are by virtue of, this Agreement through mutual agreement. If the controversy is not resolved by mutual agreement, then the Company shall request GovGuam in writing to issue a final decision within sixty days after receipt of the written request. If GovGuam does not issue a written decision within sixty days after written request for a final decision, or within such longer period as may be agreed upon by the parties, then the Company may proceed as though GovGuam had issued a decision adverse to the Company. GovGuam shall immediately furnish a copy of the decision to the Company, by certified mail with a return receipt requested, or by any other method that provides evidence of receipt. GovGuam's decision shall be final and conclusive, unless fraudulent or unless the Company appeals the decision. This subsection applies to appeals of GovGuam's decision on a dispute. For money owed by or to GovGuam under this Agreement, the Company shall appeal the decision in accordance with the Government Claims Act by initially filing a claim with the Office of the Attorney General no later than eighteen months after the decision is rendered by GovGuam or from the date when a decision should have been rendered. For all other claims by or against GovGuam arising under this Agreement, the Office of the Public Auditor has jurisdiction over the appeal from the decision of GovGuam. Appeals to the Office of the Public Auditor must be made within sixty days of GovGuam's decision or from the date the decision should have been made. The Company shall exhaust all administrative remedies before filing an action in the Superior Court of Guam in accordance with applicable laws. The Company shall comply with GovGuam's decision and proceed diligently with performance of this Agreement pending final resolution by the Superior Court of Guam of any controversy arising under, or by virtue of, this Agreement, except where the Company claims a material breach of this Agreement by GovGuam. However, if GovGuam determines in writing that continuation of services under this Agreement is essential to the public's health or safety, then the Company shall proceed diligently with performance of the Agreement notwithstanding any claim of material breach by GovGuam.

ARTICLE 12

Governing Law

The rights and responsibilities of the parties and their respective officers, directors, employees, agents and representatives under this Agreement and their performance hereunder shall be governed by the laws of Guam.

ARTICLE 13

Miscellaneous

§13.1 Government Laws and Regulation. Company guarantees the negotiated rates shall remain in effect for the Plan Year. However, if during such year the Government of the United States or GovGuam enacts statutes or promulgates regulations which (i) require that the Company offer different coverage to Covered Persons than that specifically provided in this Agreement; or (ii) causes an increase or decrease in Provider rates or other costs, the parties reserve the right on thirty (30) days written notice to the other to adjust the Premiums if the parties mutually determine that such mandate or law shall

change Company's costs under this Agreement by more than five percent (5%). Where the Agreement indicates that a PPACA requirement might override a specific limitation, this section 13.1 shall apply if it is determined that a PPACA override is in fact required.

§13.2 Contingent Fee Warranty. Company warrants that it has not retained anyone to solicit or secure this Agreement for payment of a commission, percentage, brokerage, or contingent fee, except for Company's bona fide employees or any bona fide established commercial selling agencies which Company may disclose to GovGuam.

§13.3 Gratuity Warranty. Company warrants that it has not violated, is not violating, and promises it shall not violate the prohibition against gratuities and kickbacks set forth in Guam Procurement Regulations at Title 2, GAR, Div. 4 §11107.

§13.4 Personal Interest Disclaimer. Company warrants that no member of any governing body of any agency of GovGuam and no officer, employee, or agent of GovGuam who exercises any functions or responsibilities in connection with the work to which this Agreement pertains has or shall have any personal interest, direct or indirect, in this Agreement, except that such members, officers or employees may be Covered Persons under the Plan. Company further warrants that no member of the Guam Legislature and no other official of GovGuam who exercises functions and responsibilities in connection with the work to which this Agreement pertains has or shall have any personal interest, direct or indirect, in this Agreement except as possible Covered Persons under the Plan.

§13.5 Captions. The captions, section numbers and article numbers and marginal notes appearing in this Agreement or in any copies of this Agreement are placed there only as a matter of convenience and in no way define, limit, or describe the scope or intent of this Agreement.

§13.6 Waiver. The waiver of any breach of this Agreement by either party shall not be deemed a waiver of any other breach or a waiver of any subsequent breach of the same nature.

§13.7 Excused Non-Performance. The parties' performance hereunder shall be excused when the failure of performance is caused by fire, explosion, acts of God, civil disorder, war, riot or other event not reasonably within the control of the party.

§13.8 Entire Agreement. This Agreement, including the Certificate and Exhibits A through G, is the entire Agreement between the parties. There are no terms or obligations other than those contained herein applicable to this Agreement. This instrument shall supersede all previous communications or representations, whether verbal or written between the parties.

§13.9 Amendment. This Agreement may only be amended upon the written consent of both parties.

§13.10 Time of Essence. Time is expressly made of the essence in this Agreement and for performance hereunder.

§13.11 Limitation of Actions. Any action in relation to this Agreement must be brought no later than one (1) year from the time such claim arises or should have been reasonably discovered.

§13.12 Third Party Rights. Nothing in this Agreement, whether expressed or implied, is intended to confer any rights or remedies under or by reason of this Agreement on any persons other than the parties to this Agreement and their respective successors and assigns.

§13.13 Successors in Interest. Each and all of the covenants, conditions, and restrictions in this Agreement shall inure to the benefit of and shall be binding upon the assignees and successors in interest of Company. However, Company

shall not be entitled to assign its interest in this Agreement, or any prior or future agreement with GovGuam, without the express written consent of GovGuam.

§13.14 Severability. If any term or provision of this Agreement or the application thereof shall to any extent be determined to be invalid or unenforceable, the remainder of this Agreement or the application of such remainder, other than as held invalid or unenforceable, shall not be affected and each term and condition of this Agreement shall be valid and be enforceable to the fullest extent permitted by law.

§13.15 Counterparts. This Agreement, including the Certificate and Exhibits A through G, may be executed by the parties in several counterparts, each of which shall be deemed to be an original copy.

§13.16 Legal Compliance. Company shall comply with applicable federal and local statutes and regulations, including the certification requirements of HIPAA and applicable requirements of PPACA and the PHSA. To the extent not preempted by the laws of the United States, this Agreement will be construed in accordance with and governed by the laws of Guam. In the event of conflict between any provision of this Agreement and applicable law, the law shall govern.

§13.17 Determination of Currency Exchange Payments. When a service is rendered outside of the United States, the claims shall be paid in accordance with Company's agreements with its participating providers. Claims for nonparticipating providers will be reimbursed using the Philippines fees as a reference. Additionally, claims incurred outside of the United States will be based on the date of service and will be converted according to the conversion rate, for cash transactions, against the U.S. Dollar as found in XE.com and for credit card transactions, against the utilized specific conversion rate for the card used. For multiple dates of service, the rate will be calculated based on the last date of service or payment, whichever is earlier in time.

§13.18 Restriction Against Contractor Employing Sex Offenders to Work at Government of Guam Venues. The Company warrants that no person convicted of a sex offense under the provisions of Chapter 25 of Title 9 Guam Code Annotated, or an offense as defined in Article 2 of Chapter 28, Title 9 Guam Code Annotated, in Guam, or an offense in any jurisdiction which includes, at a minimum, all of the elements of said offenses, or who is listed on the Sex Offender Registry, shall work for the Company on property of the government of Guam other than a public highway. Further, the Company warrants that if any person providing services on behalf of the Company is convicted of a sex offense under the provisions of Chapter 25 of Title 9 Guam Code Annotated or an offense as defined in Article 2 of Chapter 28, Title 9 Guam Code Annotated or an offense in another jurisdiction with, at a minimum, the same elements as such offenses, or who is listed on the Sex Offender Registry, that such person will be immediately removed from working at such agency and that the administrator of said agency be informed of such within twenty-four (24) hours of such conviction.

§13.19 Ethical Standards. With respect to this Agreement and any other contract the Company may have, or wish to enter into, with any government of Guam agency, Company represents that it has not knowingly influenced, and promises that it will not knowingly influence, any government employee to breach any of the ethical standards set forth in the Guam Procurement Law and in any of the Guam Procurement Regulations.

§13.20 Minimum Wages As Determined by U.S. Government. Company agrees to comply with Title 5, Guam Code Annotated, Sections 5801 and 5802. In the event that Company employs persons whose purpose, in whole or in part, is the direct delivery of service contracted by the Government, then the Company shall pay such employees, at a minimum, in accordance with the U.S. Department of Labor Wage Determination for Guam and the Commonwealth of the Northern Marianas Islands in effect on the date of this Agreement. In the event that this Agreement is renewed by the Government and the Contractor, at the time of the renewal, Company shall pay such employees in accordance with the Wage Determination for Guam and the Commonwealth of the Northern Marianas Islands promulgated on a date most recent to the renewal date. Company agrees to provide employees whose purpose, in whole or in part, is the direct delivery of service contracted by the Government those mandated health and similar benefits having a minimal value as detailed in the U.S. Department of Labor Wage Determination for Guam and the Commonwealth of the Northern Marianas Islands, and guarantee such employees a minimum of ten (10) paid holidays per annum per employee.

18-0373

IN WITNESS WHEREOF, GovGuam and Company have signed this Agreement on the aforementioned date.

TakeCare Insurance Company, Inc.

Government of Guam

By:

Jeffrey Larsen
President

By:

Director, Department of Administration
Acting

Date:

12/8/17

Date:

5-7-18

Effective Date

October 1, 2017

By:

Insurance Commissioner,
Department of Revenue & Taxation
Acting

Date:

6/6/18

By:

Director, Bureau of Budget and
Management Research
bm415

Date:

JUN 15 2018

CLEARED PER
BBMR'S REVIEW

Approved as to Legality and Form:

By:

ELIZABETH BARRETT-ANDERSON
Attorney General

Date:

8/31/18

Doc 18-0373

By:

The Honorable Raymond S. Tenorio
Lieutenant Governor of Guam

Date:

9/21/2018

DEPARTMENT OF ADMINISTRATION
DIVISION OF ACCOUNTS

Registration Date 09/21/2018

Registration No. C18064015

Vendor No. 70093193

Registered By: R 10/08/2018

RECEIVED

16-27-18 SOL 218351
OFFICE OF THE ATTORNEY GENERAL
SOLICITORS DIVISION 2
01-05-18

RECEIVED

JUN 11 2018

Bureau of Budget and
Management Research

**GOVERNMENT OF GUAM
AND
TAKECARE INSURANCE COMPANY, INC.
GROUP HEALTH INSURANCE CERTIFICATE
GOVGUAM HSA 2000**

**FOR THE PERIOD OF:
OCTOBER 1, 2016 – SEPTEMBER 30, 2017**

GOVERNMENT OF GUAM
and
TAKECARE INSURANCE COMPANY, INC.
GROUP HEALTH INSURANCE CERTIFICATE
GOVGUAM HSA 2000

This Certificate, including Exhibits A through G, describes the group health insurance benefits that shall be provided to each Covered Person, the circumstances under which the benefits shall be provided, limitations on and exclusions from benefits, and provisions for termination of benefits. No benefits are available under the Plan, except as set forth herein. In the event of conflict between the provisions of this Certificate and those of Exhibits A through G, the provisions of this Certificate shall govern.

ARTICLE 1

Conditions

§1.1 Agreement definitions. The definitions contained in Article 2 of the Group Health Insurance Agreement by and between GovGuam and Company ("Agreement"), to which this Certificate is attached, apply to this Certificate unless a term is otherwise defined herein.

§1.2 Scope of benefits: Company shall provide only the benefits described in this Certificate. Covered Person shall be responsible for payment of:

1.2.1 Deductibles;

1.2.2 Co-Payments and Co-Insurance;

1.2.3 Any difference between a Non-Participating Provider's charges and Company's reimbursement to such Provider;

1.2.4 Services that are not covered under this Certificate;

1.2.5 Otherwise Covered Services that exceed the maximums provided under this Certificate;

1.2.6 Services received while the individual is not covered under this Certificate; and

1.2.7 All benefits are subject to the terms and conditions contained in this Agreement, including all applicable conditions, limitations and exclusions.

§1.3 Deductible: Under this Plan, there is no Deductible for Dental Benefits (as defined in Article 7 of this Certificate), and there is no Deductible when Participating Providers are utilized for PPACA Preventive Care Services, but there is a Deductible for other Medical Benefits (as defined in Article 2 of this Certificate). Payments by a Covered Person for Dental Benefits shall not be applied to the Deductible for Medical Benefits. Any costs paid towards the Deductible applicable to Participating Providers do not accumulate towards the Deductible applicable to Non-Participating Providers.

The Deductible shall be accumulated by each Covered Person during the Plan Year. The Deductible for this Plan is \$2,000 for Covered Services received through Participating Providers per Covered Person, with a Family maximum of \$4,000 for Covered Services received through Participating Providers. There is a separate Deductible of \$4,000 per Covered Person, with a Family maximum of \$12,000 for Covered Services received through Non-Participating Providers. The Deductible for Class I is \$2,000, and \$4,000 for Class II through IV. If an individual member enrolled in Classes II, III or IV of a family plan meets \$2,600 in covered expenses, the Plan begins to pay for covered expenses for that individual.

§1.4 Co-Insurance. Co-Insurance shall be in addition to the Deductibles. The Co-Insurance shall be paid by each Covered Person, if applicable, during each Plan Year, subject to the maximum amounts provided in the Plan as indicated in the charts in Exhibits A and B. No Co-insurance shall be imposed when Participating Providers are utilized for preventive care as required by PPACA.

§1.5 Exceptions to Out of Pocket Maximums. The following payments do not accumulate towards the Out of Pocket Maximums: (a) payments for Services which are not covered; (b) payments for otherwise Covered Services that exceed the Plan's maximums; (c) payments for Services of Non-Participating Providers; and (d) payments for Dental Benefits under the optional dental plan. All other out-of-pocket expenses for covered benefits shall count towards the deductible and out-of-pocket maximum.

§1.6 Deductibles, Co-Payments and Co-Insurance for Participating and Non-Participating Provider Charges. The Deductibles, Co-Payments and Co-Insurance for Covered Persons shall, in most cases, be separate for Participating Providers and for Nonparticipating Providers. Subject to the limitations set forth in this Certificate, including Exhibits A and B the Covered Person shall pay Deductibles, Co-Payments and Co-Insurance for Covered Services for Medical Benefits and Dental Benefits indicated in Exhibits A and B. Deductibles, Co-Payments and Co-Insurance shall be based on the Eligible Charges for Covered Services. Out of Pocket Maximums for Covered Services, including Deductibles, Co-Insurances and Co-Payments for Participating Providers, regardless of whether the costs were incurred in Guam or outside Guam, shall be \$4,000 per Covered Person and \$12,000 per Family. Only payments for Covered Services rendered by Participating Providers will accumulate towards the Out of Pocket Maximums. No Deductibles, Co-Payments or Co-Insurance shall be imposed when Participating Providers are utilized for PPACA Preventive Care Services only. The Out-of-Pocket Maximum for Class I is \$4,000; and \$12,000 for Class II through IV. Co-payments and co-insurances do not accumulate towards the deductible, but accumulate towards the out of pocket maximum.

There are no Out of Pocket Maximums for Non-Participating Providers.

§1.7 LIMITATIONS ON BENEFITS. A COVERED PERSON UTILIZING A NON-PARTICIPATING PROVIDER SHALL BE RESPONSIBLE FOR ANY AMOUNT BY WHICH SUCH PROVIDER'S CHARGES EXCEED ELIGIBLE CHARGES.

However, and notwithstanding any other provision of this Agreement, in no event will a Covered Person's Co-Payment or total Out-of-Pocket Expense, due to Out-of-Service Area Emergency Services rendered by a Non-Participating Provider, exceed what they would have been if the Service had been rendered by a Participating Provider, provided the Covered Person's medical condition precluded

receiving care from a Participating Provider. Covered Person shall be responsible for any amount by which the Non-Participating Provider exceeds eligible charges for Emergency cases only. In the case of a PPACA Emergency, the Covered Person's Co-Payments or Co-Insurance for PPACA Emergency Services rendered by a Non-Participating Provider shall not exceed what they would have been if the PPACA Emergency Service had been rendered by a Participating Provider, whether or not the Emergency Care could have been received from a Participating Provider.

ARTICLE 2

Medical Benefits

Medical Benefits. Subject to the terms and conditions of this Agreement, payment for the Covered Services contained in this Article 2 ("Medical Benefits") shall be paid by Company when provided in accordance with this Agreement.

§2.1 Physician Services. Visits to or by a Physician for a non-Surgical health Services as a Covered Person may require in the treatment of an Injury or Illness.

2.1.1 Primary Care Services. As required by Section 2719A of the PHSA, as added by PPACA, each Covered Person shall be entitled to designate any Participating Provider who is a Primary Care Physician and who is available to accept the Covered Person as the Primary Care Physician for that Covered Person. If the Covered Person is a child, the child's parents shall be entitled to select for the child a Primary Care Physician who specializes in pediatric care.

- Office visits with your Primary Care Physician during office hours
- Treatment for illness and injury
- Routine physical examinations
- Well-child care from birth, including immunizations and booster doses
- Annual prostate screening (PSA) and digital exam for males age 40 and over, and for males considered to be at high risk who are under age 40
- Routine gynecological examinations and Pap smears for females, performed by your Primary Care Physician or a participating gynecologist. No referral to a gynecologist is required for a female to obtain covered gynecological care from a gynecologist.
- Annual mammography screening for asymptomatic women age 40 and older

Note: Diagnostic mammography for women with signs or symptoms of breast disease is covered as medically necessary.

- Breast pumps and breast feeding supplies, not including disposable items as part of women's preventive health in accordance with PPACA.
- Routine immunizations (except those required for travel/work)
- Annual eye examinations without a referral to a participating provider
- Routine hearing screenings

2.1.2 Specialist Care Services. Services provided by a medical specialist to whom a patient has been referred, usually by a primary care provider.

- Participating specialist office visits.

- Participating specialist consultations, including second opinions.
- Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center. All outpatient surgery must be approved in advance by the Company.
- Preoperative and postoperative care.
- Casts and dressings.
- Radiation therapy.
- Cancer chemotherapy.
- Short-term cardiac rehabilitation provided on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis for the treatment of reversible pulmonary disease.
- Hearing Aids - Coverage will be provided for medically necessary expenses incurred in the purchase of a hearing aid for Covered Persons. Hearing aid replacement when it is medically necessary and prescribed by a licensed physician or audiologist. Coverage is limited to \$500 per covered person per plan year. Replacement once every twenty four months.

2.1.3 Home or office visit. Each home or office visit, including charges for injections, inclusive of materials.

2.1.4 Hospital or Skilled Nursing Facility visit. Visit to a Covered Person who is a Registered Bed Patient at a Hospital or Skilled Nursing Facility.

2.1.5 Intensive Care Unit visit. A visit for a critical Injury or Illness provided that the Covered Person is a Registered Bed Patient.

§2.2 Preventive Physical Exam. A routine preventive physical examination (including limited hearing testing and mammograms in accordance with the U.S. Preventive Services Task Force Recommendations with a Grade A or B only). Physical examinations required for obtaining or continuing any employment, insurance, schooling or licensing are excluded from this benefit. Coverage for routine preventive physical exam is limited to one exam per plan year.

2.2.1 PPACA Preventive Care Services (with no Deductibles, Co-Payments or Co-Insurance) when provided by Participating Providers.

2.2.2 Preventive Laboratory Services are covered at One Hundred percent (100%) with no copayment, co-insurance, or deductibles in accordance with PPACA.

2.2.3 Routine preventive physical examination coverage at a Participating Provider in the Philippines with no maximum.

§2.3 Immunizations. Charges incurred in connection with immunizations in accordance with the guidelines provided by the United States Preventive Services Task Force. See Exhibit D, 'Schedule of Covered Immunizations.'

§2.4 Injections. Other than immunizations, an infusion method of putting fluid into the body, usually with a hollow needle and a syringe which is pierced through the skin to a sufficient depth for the material to be forced into the body. There are several methods of injection or infusion, including intradermal, subcutaneous, intramuscular, intravenous, intraosseous, and intraperitoneal.

§2.5 Allergy testing. A maximum benefit of One Thousand Dollars (\$1000) per Plan Year per Covered Person for charges for allergy testing.

§2.6 Maternity. Hospital and Physician charges for maternity Services, including prenatal, postnatal, delivery and Newborn care, in accordance with all applicable restrictions thereon, and to include coverage for epidural injections when medically indicated. Provided, however, that Newborn care shall not be provided to a child born to a non-Spouse Dependent even if the non-Spouse Dependent's own prenatal, postnatal and delivery care are covered.

§2.7 Well Child Care. Charges incurred by a Covered Person from newborn to seventeen (17) years of age for services rendered solely for the purpose of health maintenance and not for the Treatment of an Illness or Injury. Payment, for such Services shall be based on the Bright Futures/American Academy of Pediatrics recommendations for Preventive Pediatric Health Care and as stated in Exhibit A. Benefits for such services may include immunization and lab tests. Services must be performed by or under the supervision of a Physician. Well Child Care will not be subject to the deductible, and shall be covered at 100% by the Company. Any such care that is PPACA Preventive Care Services shall be covered without Deductibles, Co-Payments or Co-Insurance if received from a Participating Provider. Charges for treatment of illness or injury shall be covered as regular benefits. If the care is PPACA Preventive Care Services, requirements of this agreement and PPACA regulations shall be followed in determining the portion of any combined visit or service that is to be provided without Deductibles, Co-Payments or Co- Insurance.

§2.8 Basic Hospital benefits. The Hospital benefits to which a Covered Person is entitled while medically necessary and reasonably confined as a Registered Bed Patient are limited to a maximum of three hundred and sixty-five (365) days of confinement during a Plan Year, in accordance with evidence based medical guidelines. If necessarily incurred during said period, the following Services shall be Covered Services:

2.8.1 Hospital Room and Board. Coverage is provided at the Hospital's most common Semi-Private room rate, or at the Hospital's daily average private or single room rate if there are no Semi-Private accommodations or if a private room is Medically Necessary.

2.8.2 Intensive Care Unit. Room and Board charges for a stay in an intensive care unit which is equipped and operated according to generally recognized Hospital standards.

2.8.3 Cardiac room. Charges for a stay in a cardiac room which is equipped and operated according to generally recognized Hospital standards.

2.8.4 Surgery. Charges for the operating room, surgical supplies, Hospital Anesthesia Services, drugs, dressings, oxygen and antibiotics.

2.8.5 Diagnostics. Charges for diagnostics to the extent the same are not provided under Article 2.9.

2.8.6 Outpatient Hospital benefits. Hospital charges incurred by a Covered Person for use of a Hospital's outpatient facilities in connection with an Injury or Illness as follows:

2.8.6.1 Emergency medical Services within twenty-four (24) hours of a serious Injury or the sudden onset of an acute Illness, or such longer time as may

be necessary to stabilize a covered individual in accordance with the emergency definitions and requirements of PPACA in the case of PPACA Emergencies.

2.8.6.2 Medical Services received on the day of and in connection with Surgery.

2.8.6.3 Pre-admission tests and/or examinations.

2.8.6.4 Medical Services which cannot be rendered in a Physician's office.

2.8.6.5 Non-Emergency. Company shall not pay for charges incurred for use of a Hospital's outpatient facilities, supplies and equipment in connection with elective minor Surgical Services, non-Emergency Services or health Services that could be received in a Physician's office. Services in the emergency setting must meet the definition of Emergency. The Company reserves the right to audit and review the claim retrospectively to validate the nature of the condition for which services were provided. The Company shall not pay for non-Emergency use of the Hospital's emergency facilities, unless the condition is urgent and treatment is unavailable elsewhere at the time.

2.8.7 Ambulatory Surgical Center benefits. Charges for Outpatient Surgery.

§2.9 **Basic Surgical benefits.** The Surgical benefits to which a Covered Person is entitled are as follows:

2.9.1 Surgical Services. Charges for Surgical Services the Covered Person may require in the treatment of an injury or illness, including charges for such Medically Necessary after visits in connection with the particular Surgical Services performed. Any charges for non-Medically Necessary after Service visits shall not be paid.

2.9.2 Anesthesiology. Charges of a private anesthesiologist or Hospital anesthesiologist when the Services of an anesthesiologist are Medically Necessary.

2.9.3 Gastric Banding and Bariatric Surgery. Gastric banding and bariatric surgery will only be covered if such treatment is in accordance with the following:

- Company covers bariatric surgery using a covered procedure outlined below as medically necessary when ALL of the following criteria are met:
 - The individual is ≥ 18 years of age or has reached full expected skeletal growth AND has evidence of EITHER of the following:
 - a BMI (Body Mass Index) ≥ 40
 - a BMI (Body Mass Index) 35-39.9 with at least one clinically significant comorbidity, including but not limited to, cardiovascular disease, Type 2 diabetes, hypertension, coronary artery disease, or pulmonary hypertension
 - Failure of medical management including evidence of active participation within the last two years in a weight-management program that is supervised either by a physician or a registered dietician for a minimum of six months without significant gaps. The weight-management program must include monthly documentation of ALL of the following components:
 - weight

- current dietary program
- physical activity (e.g., exercise program)

Programs such as Weight Watchers®, Jenny Craig® and Optifast® are acceptable alternatives if done in conjunction with the supervision of a physician or registered dietician and detailed documentation of participation is available for review. For individuals with long-standing, morbid obesity, participation in a program within the last five years is sufficient if reasonable attendance in the weight-management program over an extended period of time of at least six months can be demonstrated. However, physician-supervised programs consisting exclusively of pharmacological management are not sufficient to meet this requirement.

- A thorough multidisciplinary evaluation within the previous 12 months which includes the following:
 - an evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure(s) and all of the associated current CPT codes
 - a separate medical evaluation from a physician other than the surgeon recommending surgery, that includes a medical clearance for bariatric surgery
 - unequivocal clearance for bariatric surgery by a mental health provider
 - a nutritional evaluation by a physician or registered dietician

2.9.4 Elective Surgery. Covered by plan in accordance with the Schedule of Benefits and must be pre-certified and approved by the plan.

2.9.5 Robotic Surgery/Robotics Suite. Covered in accordance with the basic surgical procedure benefits as indicated on the Schedule of Benefits. Robotic surgery/Robotic Suite must be pre-certified by the plan.

2.9.6 Organ Transplant. Covered in accordance with basic surgical procedure benefits as indicated on the Schedule of Benefits. Transplant must be pre-certified and approved by the plan. Only the services, care and treatment received for, or in connection with, the pre-approval transplant of organs, which are determined by the Plan to be medically necessary services and which are not experimental, investigational or for research purposes except as permitted through approved clinical trials will be covered by the Plan.

§2.10 Basic diagnostic and therapy benefits.

2.10.1 Provider Services. Charges for the following Services when ordered by a Physician for the treatment of an Injury or Illness.

- 2.10.1.1 Laboratory Services. Charges for laboratory Services.
- 2.10.1.2 X-ray Services. Charges for diagnostic X-ray procedures.
- 2.10.1.3 Electrocardiograms. Charges for EKG procedures.
- 2.10.1.4 Radiotherapy. Charges for radiotherapy.
- 2.10.1.5 Inhalation Therapy. Charges for Inhalation Therapy provided as an Outpatient Service.
- 2.10.1.6 Sleep apnea Studies/Polysomnograph. Charges for sleep apnea studies/ polysomnograph-diagnostic and therapeutic procedures.

§2.11 Medical-related Dental Benefits. The following dental benefits are Covered Services:

2.11.1 Services rendered by a Dentist or Physician, and Hospital or Ambulatory surgi-center services related thereto, when required to treat traumatic injury to sound, natural teeth or jaw. Coverage is limited to palliative care to alleviate pain and other acute symptoms resulting from the Injury. Such may include debridement of wounds, suturing, extraction of broken teeth, splinting of loose teeth, wiring of jaws, smoothing jagged edges of broken teeth. Services must be completed within 12 months following the injury. Fillings, crowns, bridges, dentures, bonding and similar permanent restorations are excluded.

2.11.2 If a Participating Physician certifies, in advance, that a non-dental, medical condition makes admission necessary to safeguard the Covered Person in connection with Dental Services rendered by a Dentist, Hospital and Ambulatory Surgi-center Services rendered in connection therewith are covered.

§2.12 Home Health Care. Home Health Care, provided by allied health care professionals, is covered according to the schedule of benefits.

§2.13 Basic Skilled Nursing Facility benefits. The following Skilled Nursing Facility benefits are provided:

2.13.1 Skilled Nursing Facility benefits. If a Covered Person is confined as a Registered Bed Patient in a Skilled Nursing Facility, the Covered Person shall be eligible for benefits as if confined in a Hospital, except that the eligible period of confinement shall be limited to a maximum of sixty (60) days per Plan Year and payment for such benefits shall be the rates applicable for such Skilled Nursing Facility. To be eligible for these benefits, each of the following requirements must be met:

2.13.2 The admission to the Skilled Nursing Facility must be approved in advance by Company.

2.13.3 The Covered Person must be admitted on the authorization of a Physician and must continue to be attended by a Physician while confined.

2.13.4 Confinement in the Skilled Nursing Facility must not be primarily for comfort, convenience, rest cure or domiciliary care.

2.13.5 If a Covered Person remains in a Skilled Nursing Facility more than thirty (30) days, the attending Physician must submit to Company an evaluation report reviewing the thirty (30) day period of confinement and addressing the specific need for continued confinement.

§2.14 Hospice Care. Charges for a maximum of one hundred eighty (180) days per lifetime. The attending Physician must determine limited life expectancy of six (6) months or less. The Covered Person shall not be entitled to benefits for any Services for the Terminal Illness except for palliative care. Services must be provided through a bona fide Hospice. Coverage for Hospice Services shall be limited to a One Hundred Fifty Dollars (\$150) per day.

2.14.1 Palliation Therapy is covered under the Hospice Care Benefit.

2.14.1.1 Palliation Therapy shall be defined as patient and family centered care that optimizes the quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs and facilitating patient autonomy, access to information and choice. Palliative care should be covered on an outpatient basis only.

2.14.2 At least one of the treating Physicians must determine limited life expectancy of six months or less and certifies terminal illness of a Covered Person.

2.14.3 There must have been agreement by the Covered Person or the Covered Person's authorized representative to begin Hospice care as palliative and/or support only; and

The Hospice level of benefits begins on the date the above conditions are met. The Covered Person shall not be entitled to any care for the terminal illness except for palliative care. Medically necessary care for unrelated conditions shall continue as covered benefits, subject to plan benefits, deductibles, exclusions and limitations, medical necessity determinations and eligibility. Benefits for conditions normally covered, and not directly or indirectly related to the terminal condition are covered for inpatient, outpatient and emergency care in accordance with the schedule of benefits.

§2.15 Prescription Drugs.

2.15.1 Charges for Prescription Drugs, including insulin and syringes, when prescribed by a Physician. Charges for Medically Necessary prescription drugs not contained on the Company's Preferred Drug Formulary shall be covered provided the Physician certifies to the Company that the non-formulary drug is Medically Necessary for the Covered Person, and that no formulary drug was appropriate.

2.15.2 Prescription Drugs shall be limited to a thirty (30) day supply except for birth control pills and mail order Prescription Drugs which may be issued in a ninety (90) day prescription.

2.15.3 Prescriptions may be refilled for a period up to six (6) months from the original date of prescription, if so specified by a Physician in writing on the prescription.

2.15.4 Prescription Unit represents the maximum amount of outpatient prescription medication that can be obtained at one time for a single co-payment. For most oral medications, a prescription unit is up to a 30-day supply of medication.

2.15.5 For other medications, a Unit represents a single container, inhaler unit, package or course of therapy. For habit-forming, a unit may be set at a smaller quantity for the covered person's protection and safety.

2.15.6 Participating Mail Order Pharmacy. A pharmacy which has contracted with Company's Pharmacy Benefits Manager to provide covered outpatient prescription drugs or medicines and insulin to Members by mail or other carrier.

2.15.7 Participating Retail Pharmacy. A community pharmacy which has contracted with Company's Pharmacy Benefits Manager to provide covered outpatient prescription drugs to Members.

2.15.8 Benefits for outpatient prescription Drug Products dispensed by a mail service Network Pharmacy. The following supply limits apply:

- As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

§2.16 Prescribed drugs in countries outside the United States may differ from those that require a prescription in the U.S. Drugs purchased outside the U.S. must be an equivalent product of one approved by U.S. federal law or there must be clinical evidence that prescribing the drug is consistent with the standard of medical practice in the country where the prescription is issued.

§2.17 Specialty Drugs: Charges for medications used to treat certain complex and rare medical conditions. Specialty drugs are often self-injected or self-administered. Many grow out of biotech research and may require refrigeration or special handling.

§2.18 Health education. Charges for health education classes and materials in accordance with Exhibit C herein provided.

§2.19 Durable Medical Equipment. The rental cost of: standard hospital bed, cane single tip, cane quad tip, crutches (forearm, aluminum OR forearm, wood), walker (folding, adjustable with wheels OR folding, adjustable without wheels), oxygen refill, oxygen concentrator, oxygen portable with regulator, suction pump with supplies, suction tubing (replaceable every 3 months), yankauer oral suction catheter, tracheostomy care kits (for new and established tracheostomies), continuous positive airway pressure (CPAP), and standard wheelchairs (to include extra-wide sizes), when prescribed by a Physician and then only at the prescribed level. If the total rental cost exceeds the purchase price, Company may, at its discretion, either rent or purchase the item for the Covered Person. This benefit is limited to one rental or purchase every three (3) years and is limited to standard equipment only, unless subject to a treatment plan.

§2.20 Mental health benefits. The charges for the diagnosis and treatment of mental illness, as that term is defined in Title 22, Guam Code Annotated, Section 28103, subject to the same conditions and restrictions applicable to physical illness.

§2.21 Ambulance Services. If a Covered Person is transported to a Hospital by ground ambulance from the place where an Injury occurred, or when prescribed by a Physician, eighty percent (80%) of the charges for such ground ambulance Services are payable if: (i) the Services are provided by a licensed ambulance service; and (ii) the transportation is to a Hospital capable of treating the Covered Person and which Hospital is nearest to the place of Injury or place of entering the ambulance.

§2.22 Tubal ligation. The charges for tubal ligations.

§2.23 Vasectomy. The charges for vasectomies on an outpatient basis only.

§2.24 Breast reconstruction. Reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all states of mastectomy, including lymphedemas, are covered. Such re-constructive procedures are not limited to re-constructive procedures necessitated by mastectomies performed while covered under this Plan.

§2.25 Blood products. Charges for blood and blood products and their administration.

§2.26 Hearing Screening. Charges for infant hearing screening as required by Title 10 GCA §§ 4101-4111, the Universal Newborn Hearing Screening and Intervention Act.

§2.27 Preventive Care. To the extent required by PPACA, preventive care (with no cost-sharing) when preventive care is provided by Participating Providers.

§2.28 Preferred Provider(s). Preferred Provider shall be defined as a Participating Provider that is a Hospital or Ambulatory Surgical Center located outside of the Service Area. The Hospital or Ambulatory Surgical Center shall be a Participating Provider at the time Services are rendered to the Covered Person and shall be specifically designated by name as a Preferred Provider in the more recent of Company's most current member brochure or Company's most current updated listing of Preferred Providers.

The following sections refer to charges incurred by a Covered Person for Covered Services provided by Preferred Providers:

2.28.1 The Covered Person has obtained written Prior Authorization from Company or Company's agent to receive Services from a Preferred Provider and has agreed to receive Services from such Preferred Provider chosen by Company or Company's agent. No Prior Authorization shall be required for Emergency or PPACA Emergency cases and the Covered Person may select the Preferred Provider where Emergency or PPACA Emergency Services shall be rendered.

2.28.2 Company is the primary payor based on the coordination of benefits provisions of this Certificate, unless the primary payor is Medicare for those Preferred Providers located in the United States; provided, however, the Company shall be the primary payor for Preferred Providers outside of the United States and located in the Philippines, Korea, Japan, or other Pacific-Asian locations.

2.28.3 For Inpatient Services which are unavailable in Guam and rendered by Preferred Providers.

2.28.3.1 Company shall pay 100% of these services.

2.28.3.2 Company shall waive any co-insurance for such Services.

2.28.3.3 Company shall only provide airfare for the Covered Person for the most direct route to and from the location of the Covered Person and the Preferred Providers as determined by Company. Regardless of the location of the Covered Person, or if it is Medically Necessary to provide for a break in the trip, Company shall provide the lesser of the lowest applicable economy airfare or the lowest economy, round-trip airfare on a commercial direct flight between Guam and the Preferred Providers. In no event shall Company provide an air ambulance.

2.28.3.4 If the Service is one of the following specific procedures or conditions: open heart surgery, oncology surgery to include but not limited to the following cancers brain, lung, liver, kidney, adrenal, nasopharyngeal, tongue, prostate, colon, genito-urinary, breast and gynecological oncology, aneurysmectomy, pneumonectomy, intra cranial surgery, acute leukemia, gamma knife or if the level of care required is NICU Level III, or if the expected cost to the Company for off-island Covered Services exceeds \$25,000.00, Company shall pay the air fare of one companion of the Covered Person to the Center of Excellence [Preferred Providers] under the terms set forth in §2.28.3.3.

2.28.3.5 If it is Medically Necessary that a licensed medical attendant be with the Covered Person, Company shall provide for one airline seat for such attendant under the same terms set forth in §2.28.3.3.

2.28.3.6 If the Covered Person is unable to self-care, Company shall provide for one airline seat for a qualified assistant under the same terms as §2.28.3.3.

2.28.3.7 Company may, at its option, make the travel arrangements for the Covered Person and his or her companion, attendant or assistant (if any) and purchase the airline tickets.

2.28.3.8 Company shall facilitate the Hospital/Physician arrangements for the Covered Person.

2.28.3.9 For Company to be liable to pay any airfare, the proposed Service to be performed at the Preferred Providers must be a specific procedure and not merely a diagnostic work-up or to confirm or rule out the diagnosis of another Physician. In the event the covered person/attendant purchases the seat(s), the Company will reimburse for actual expenses incurred in purchasing Medically Necessary seat(s), but not more than the Company would have paid had it purchased the seat(s) for the companion in advance. In no event will company reimburse for any seat(s) purchased with frequent flyer miles.

2.28.4 For Inpatient and Ambulatory Surgical Center Services which are unavailable in Guam and rendered by Preferred Providers:

2.28.4.1 Company shall waive the twenty percent (20%) Co-Insurance.

2.28.4.2 Company shall facilitate the Surgicenter/Physician arrangements for the Covered Person.

2.28.5 Only those facilities identified as Preferred Providers in the Company's most recently updated Provider Directory will qualify for the airfare benefit.

§2.29 If no Participating Provider available. If there is no Participating Provider available, within the United States, to provide necessary Covered Services to a Covered Person, Company will cover those services at a Non-Participating Provider, within the United States, unless otherwise agreed by the Covered Person, such that the Covered Person will have no greater out-of-pocket cost than he or she would have had had the Services been rendered by a Participating Provider.

§2.30 If not able to travel. In case Emergency medical care is needed off-island, and it is medically imprudent for the Covered Person to be transported to a Participating Provider, Company will cover Services rendered to the Covered Person at a Non- Participating Provider such that the Covered Person will have no greater out-of-pocket cost than he or she would have had had the Services been rendered by a Participating Provider.

ARTICLE 3

Specific Limitations on Benefits

§3.1 **Dollar limitations.** The medical benefits available under this Agreement are subject to the following specific dollar limitations per Covered Person, in addition to all other exclusions and limitations set forth in the Agreement and this Certificate:

3.1.1 **Maximum Annual Benefit.** The total benefits payable to or on behalf of a Covered Person shall be unlimited per Plan Year.

3.1.2 **Cardiac surgery.** Benefits for cardiac surgery, including, but not limited to catheterization, angioplasty, valve replacement/repair, bypass and pacemaker are included.

3.1.3 **Non-Spouse Dependent.** Maternity benefits for a non-Spouse Dependent are covered. Except that Newborn care shall not be covered for a child born to a non-Spouse Dependent. A child born to a non-Spouse Dependent shall not be covered unless such child specifically meets the

requirements for coverage as a Dependent of an employee (such as the employee becoming the guardian of such child).

3.1.4 Nuclear medicine. Coverage for nuclear medicine and all Covered Services related thereto are included.

3.1.5 Orthopedic conditions. Coverage for orthopedic conditions and related internal and external prosthetic devices are included.

3.1.5.1 Except as specifically limited under this Agreement, Services, supplies and devices related to the treatment of chronic or acute orthopedic conditions are covered. This includes, but is not limited to:

3.1.5.1.1 Prosthetic devices. Devices, including artificial joints, limbs and spinal segments.

3.1.5.1.2 Orthotic devices. Orthotic devices, which are defined as appliances or apparatus that support or align movable parts of the body, correct deformities or improve the functioning of movable parts of the body.

3.1.6 Radiation therapy. Coverage for radiation therapy and all Services related thereto shall be included.

3.1.7 Allergy testing. A maximum benefit of One Thousand Dollars (\$1000) per Plan Year for charges for allergy testing that are not considered essential benefits under PPACA. Benefits for Allergy testing and treatment that constitute essential benefits under PPACA are subject only to the PPACA Annual Limit.

3.1.8 Annual refraction eye examination. Coverage for annual eye examination is once per member per Plan Year.

3.1.9 Blood and blood products and derivatives. Coverage for blood and blood products/derivatives and services related thereto shall be included.

3.1.10 Hearing aids. Coverage for hearing aids is limited to Five Hundred Dollars (\$500) per Plan Year. Replacements for hearing aids are allowed once every two years.

3.1.11 Acupuncture. Coverage for Acupuncture Services is up to a maximum of thirty (30) visits per Plan Year as stated in Exhibit A.

3.1.12 Chemical dependency treatment. Coverage for the diagnosis and necessary treatment of chemical dependency shall not be subject to a dollar limit other than being included under the PPACA Annual Limit.

3.1.13 Chiropractic. Coverage for Chiropractic Services is up to a maximum of thirty (30) visits per Plan Year as stated in Exhibit A.

3.1.14 Occupational Therapy. Coverage for Occupational therapy is up to a maximum of twenty (20) visits per Plan Year as stated in Exhibit A.

3.1.15 Respiratory Assist Devices. Coverage for Respiratory Assist Devices (RAD) is based upon medical necessity and will be in accordance with published Medicare Guidelines of coverage at the time of service.

§3.2 Other benefit limitations. The medical benefits available under this Agreement are subject to the following other benefit limitations, in addition to all other exclusions and limitations set forth in the Agreement and this Certificate, per Covered Person:

3.2.1 Emergency Services. Coverage for Emergency Services is generally limited to those Services required for diagnosis and treatment of an Emergency immediately after onset, no later than twenty-four (24) hours. PPACA Emergency Services shall be provided as necessary to stabilize the Covered Person, without regard to such time limit.

3.2.2 Hospital and Surgical authorization. Prior Authorization must be obtained from the Company before a Covered Person is admitted to a Hospital or has one of the Surgeries or Medical Procedures listed in §3.2.2.2. Prior Authorization will be handled in accordance to the Milliman Healthcare Guidelines.

3.2.2.1 Responsibility for Prior Authorization. The Participating Provider ordering the hospitalization or Surgery for a Covered Person shall obtain Prior Authorization. The Covered Person shall not be responsible for obtaining Prior Authorization and shall not be liable for any penalty.

The Non-Participating Provider or the Covered Person shall be responsible for obtaining Prior Authorization required by the Company prior to the hospitalization or Surgery. In the event a Covered Person is admitted to a Hospital for an Emergency, required authorization consists of notifying Company (i) within forty eight (48) hours of the admission if it occurs on a day other than a Saturday, Sunday or holiday; or (ii) within seventy-two (72) hours if it occurs on a Saturday, Sunday or holiday, and, in either case, receiving Company's authorization for the admission. PPACA Emergency Services shall not require Prior Authorization, and such services provided by Non-Participating Providers shall not require any notification or other administrative requirement other than what is required when provided by Participating Providers.

Prior Authorization denials shall be handled pursuant to the PPACA Claims Procedure Requirements provided in §6.7, to the extent required by PPACA.

3.2.2.2 Reduced benefit without Prior Authorization. If a required Prior Authorization is not obtained in accordance with this §3.2.2, Company shall pay fifty percent (50%) of the Eligible Charges incurred in connection with the confinement or Surgery. If the Participating Provider is the person required to obtain the Prior Authorization, the reduction in benefits shall not be charged to the Covered Person. No penalty for failure to obtain Prior Authorization shall be imposed for a PPACA Emergency, whether Participating or Non-Participating Providers are utilized.

List of outpatient and inpatient procedures requiring authorization (unless a PPACA Emergency). If the following procedures are not pre-certified by plan, payment may be denied.

- AIDS treatment
- All elective outpatient surgical procedures requiring use of surgical facilities
- All out of service area services and procedures
- Any and all diagnostics in excess of \$300.00 including specialty laboratory
- Any back or disc surgery
- Any knee surgery
- Any procedure requiring implants
- Any procedure requiring orthopedic devices and/or prosthetics
- Any varicose veins surgery
- Breast reconstruction surgery
- Carpal Tunnel Release
- Durable Medical Equipment: Standard hospital bed, wheelchairs, walkers, crutches, oxygen, suction machine, CPAP machine
- EMG/NCT (upper extremities)
- End Stage Renal Disease treatment /Hemodialysis
- Gall Bladder Surgery
- Heart By-Pass Surgery
- Cardiac surgery
- Chemotherapy
- Heart catheterization
- Hernia surgery
- Hysterectomy
- Mastectomy
- MIBI Scan, Thallium Stress Test, Exercise Stress Test
- MRI (All)
- Non-Routine Endoscopies and Colonoscopies
- Pain Management Studies
- Physical Therapy requiring more than five (5) out-patient visits
- Prostatectomy
- Radiological and nuclear diagnostic procedures performed or ordered by the same provider on any one patient two or more time
- Ultrasounds (All with the exception of the first OB ultrasound & first FNST)
- Upper GI Endoscopy
- Robotic Suite and Robotic Surgery
- Clinical trials
- Congenital treatment
- Hyperbaric Oxygen treatment

3.2.3 Excess Non-Participating Provider charges. The Covered Person shall be responsible for charges by a Non-Participating Provider in excess of Eligible Charges, except (a) Out-Of-Service Area emergency, or (b) when the Non-Participating Provider is a Sole Source Provider as defined in §7.9 of the Agreement. A Covered Person using a Non-Participating Provider for a PPACA Emergency shall not be liable for Co-Payments or Co-Insurance in excess of Co-Payments and Co-Insurance that would have been charged if Participating Providers had been used. The Company shall pay an amount for PPACA Emergency Services computed as provided in this Agreement.

3.2.4 Excessive Participating Provider charges. Neither the Covered Person nor the Company shall be liable for charges by a Participating Provider in excess of the Eligible Charges. These charges shall be the responsibility of the Participating Provider.

3.2.5 Physical therapy. Charges for the first twenty (20) visits to a licensed physical therapist for physical therapy, including neuromuscular rehabilitation. After twenty (20) visits in a Plan Year, Company shall pay fifty percent (50%) of Eligible Charges.

3.2.6 Pregnancy termination. Charges for the termination of Pregnancy is covered only when Medically Necessary.

3.2.7 Skilled Nursing Facility care. Coverage for Skilled Nursing Facility Services is limited to sixty (60) days maximum per Plan Year.

3.2.8 Well Child Care. Well Child Care is covered only as set forth in §2.8 and as required by PPACA (as a PPACA Preventive Care Services or otherwise).

3.2.9 Case Management. Company may, in its discretion, assign Nurses or other qualified health professionals for the purpose of Case Management. Payment for alternative Services in one instance does not obligate the Company to provide the same or similar benefits for the same or any other Covered Person in any other instance. Payment of these alternative benefits is made as an exception and in no way changes or voids the benefits, terms or conditions of this Agreement.

ARTICLE 4

Specific Exclusions from Benefits

§4.1 No benefits will be paid for Injury or Illness, (a) when the Covered Person is entitled to receive disability benefits or compensation (or forfeits his or her right thereto) under Worker's Compensation or Employer's Liability Law for such Injury or Illness or (b) when Services for an Injury or Illness are rendered to the Covered Person by any federal, state, territorial, municipal or other governmental instrumentality or agency without charge, or (c) when such Services would have been rendered without charge but for the fact that the person is a Covered Person under the Plan.

§4.2 No benefits will be paid if any material statement made in an application for coverage, enrollment of any Dependent or in any claim for benefits is false. Upon identifying any such false statement, Company shall give the Covered Person at least 30 days notice that his or her benefits have been suspended and that his or her coverage is to be terminated. If the false statement is fraudulent or is an intentional misrepresentation of a material fact, such termination shall be retroactive to the date coverage was provided or continued based on such fraudulent statement or intentional misrepresentation of material fact. If the false statement was not a fraudulent statement or intentional misrepresentation of material fact, termination of coverage shall be effective no earlier than the date of the suspension. The Covered Person may dispute any termination of coverage by filing a claim under the PPACA Claims Procedure for internal or external appeals, set out in §6.7 of this Certificate. If an appeal under §6.7 is filed, the resolution of the matter shall be in accordance with the outcome of the appeal proceedings. If no appeal is filed for any retroactive termination and the Company paid benefits prior to learning of any such false statement, the Subscriber must reimburse the Company for such payment. Terminations of coverage shall be handled in accordance with the applicable claims procedure requirements of Section 2719 of the PHSA, as added by PPACA. Retroactive terminations of coverage shall not violate the applicable prohibitions on rescissions of Section 2712 of the PHSA, as added by PPACA, and rescissions shall be handled in compliance with PPACA's applicable claim denial requirements.

§4.3 No benefits will be paid for confinement in a Hospital or in a Skilled Nursing Facility if such confinement is primarily for custodial or domiciliary care. (Custodial or domiciliary care includes that care which consists of training in personal hygiene, routine nursing services and other forms of self care. Custodial or domiciliary care also includes supervisory services by a Physician or Nurse for a person who is not under specific medical or surgical treatment to reduce his or her disability and to enable that person to live outside an institution providing such care.) Company and not Covered Person shall be liable if the Company approves the confinement, regardless of who orders the service.

§4.4 No benefits will be paid for nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)

§4.5 No benefits will be paid for private Duty Nursing. This provision does not apply to Home Health Care.

§4.6 No benefits will be paid for special medical reports, including those not directly related to treatment of the Member. (e.g., Employment or insurance physicals, and reports prepared in connection with litigation.)

§4.7 No benefits will be paid for services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.

§4.8 No benefits will be paid for court ordered services, or those required by court order as a condition of parole or probation.

§4.9 No benefits will be paid for Services and supplies provided to a Covered Person for an Injury or Illness resulting from an attempted suicide by that Covered Person unless resulting from a medical condition (including physical or mental health conditions) or from domestic violence.

§4.10 No benefits will be paid for Services and supplies provided in connection with intentionally self-induced or intentionally self-inflicted injuries or illnesses unless resulting from a medical condition (including physical or mental conditions) or from domestic violence.

§4.11 No benefits will be paid for Services and supplies provided to a Covered Person for Injuries incurred while the person was committing a criminal act.

§4.12 Unless otherwise specifically provided in the Agreement, no benefit will be paid for, or in connection with, airfare and the Company will not pay for the transportation from Guam to any off-island facility, nor for any other non-medical expenses such as taxes, taxis, hotel rooms, etc. In no event will the Company pay for air ambulance or for the transportation of the remains of any deceased person.

§4.13 No benefits will be paid for living expenses for Covered Persons who require, or who of their own accord seek, treatment in locations removed from their home.

§4.14 No benefits will be paid for Services and supplies provided to a dependent of a non-Spouse Dependent. Dependents of non-Spouse Dependents are not eligible for coverage. For example, when a Dependent, other than a Spouse of the Subscriber, has a child, that child is a dependent of a non-Spouse Dependent and is not eligible to become covered under the Plan, unless such child otherwise becomes eligible for enrollment.

§4.15 No benefits will be paid for home uterine activity monitoring.

§4.16 No benefits will be paid for services performed by an immediate family member for which, in the absence of any health benefits coverage, no charge would be made. Immediate family member is defined as parents, spouses, siblings, or children of the insured member.

§4.17 No benefits will be paid for treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. If a Member is covered under a Workers' Compensation law or similar law, and submits proof that the Member is not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational" regardless of cause. The Covered Benefits under the Group Health Insurance Certificate for Members eligible for Workers' Compensation are not designed to duplicate any benefit to which they are entitled under Workers' Compensation Law. All sums payable for Workers' Compensation services provided under the Group Health Insurance Certificate shall be payable to, and retained by Company. Each Member shall complete and submit to Company

such consents, releases, assignments and other documents reasonably requested by Company in order to obtain or assure reimbursement under the Workers' Compensation Law

§4.18 No benefits will be paid for:

- 4.18.1 Drugs or substances not approved by the Food and Drug Administration (FDA), or
- 4.18.2 Drugs or substances not approved by the FDA for treatment of the illness or injury being treated unless empirical clinical studies have proven the benefits of such drug or substance in treating the illness or injury, or
- 4.18.3 Drugs or substances labeled "Caution: limited by federal law to investigational use."
or
- 4.18.4 Any drug or substance which does not, by federal or state law, require a prescription order (i.e., an over-the-counter (OTC) drug).

§4.19 No benefits will be paid for experimental or Investigational Procedures, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes unless deemed medically necessary by the patient's physician, are associated with a qualifying clinical trial per PPACA regulations, and pre-authorized by the Company.

Per PHSA sec. 2709(a)(2), added by PPACA sec 10103(c), the plan must pay for items and services furnished in connection with approved clinical trials, and cannot exclude such items and services based on an exclusion for experimental or investigational treatments. The requirement mandates coverage of all medically necessary charges associated with the clinical trial, such as physician charges, labs, X-rays, professional fees and other routine medical costs.

An approved clinical trial is defined as:

- Phase I, Phase II, Phase III, or Phase IV clinical trial,
- Being conducted in relation to the prevention, detection or treatment for Cancer or other life threatening disease or condition, and
- Is one of the following:
 - 1. A federally funded or approved trial.
 - 2. A clinical trial conducted under an FDA investigational new drug application.
 - 3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

§4.20 No benefits will be paid for services or supplies related to Genetic Testing except as may be required by the PPACA.

§4.21 No benefits will be paid for any item or substance that is available without a Physician's prescription even if prescribed by a Physician, except as otherwise provided herein and except for medicines and supplies Medically Necessary for inpatient care.

§4.22 No benefits will be paid for Services and supplies provided to perform transsexual surgery or to evaluate the need for such surgery. Evaluations and subsequent medications and Services necessary to maintain transsexual status are also excluded from coverage, as are complications or medical sequela of such surgery or treatment.

§4.23 No benefits will be paid for injuries incurred by the operator of a motorized vehicle while such operator is under the influence of intoxicating alcoholic beverage, controlled drugs, or substances. If

a blood alcohol level or the DRAEGER ALCO TEST is available and shows levels that are equal to or exceed 0.08 grams percent (gms%) or that exceed the amount allowed by law as constituting legal intoxication, no benefits will be paid.

§4.24 No benefits will be paid for any medical Service or supply which is available to the Covered Person on Guam and which is paid by or reimbursable through a governmental agency or institution that provides medical and healthcare services to low-income or indigent persons, provided, however, this exclusion *shall* not apply to the treatment of any communicable disease as defined in Article 3 of Chapter 3, Title 10, Guam Code Annotated, and for which the Company *shall* pay for medical services and supplies as is medically necessary for the treatment of Covered Person. However, notwithstanding the aforesaid, in no event will the Company consider the availability of benefits under Medicaid or Medically Indigent Program when paying benefits under this Agreement.

§4.25 No benefits will be paid for dental services including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, dental splint and other dental appliances, root canal treatment, soft tissue impactions, alveolectomy, augmentation, and vestibuloplasty, treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, maxillary and mandible implants (Osseo integration) and all related services, removal of impacted teeth, bite plates, orthognathic surgery to correct a bit defect. This exclusion does not apply to:

4.25.1 Removal of bony impacted teeth, bone fractures, removal of tumors, and biopsy or excision of oral cysts

4.25.2 Emergency Services to stabilize an acute injury to sound natural teeth, the jawbone or surrounding structures, if provided within 48 hours of the injury or as required by PPACA to stabilize and treat a PPACA Emergency.

4.25.3 Surgical treatment of TMJ as described in the Covered Benefits Section "Temporomandibular Joint Syndrome (TMJ) Services".

4.25.4 Dental anesthesia when provided according to the conditions described in the Covered Benefits Section, "Limited General Anesthesia for Dental Procedures".

4.25.5 Procedures deemed medically necessary by patient's physician and pre-authorized by Company.

§4.26 No benefits will be paid in connection with elective abortions unless Medically Necessary.

§4.27 No benefits will be paid for vision care services, including orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision), lasik, keratoplasty, and radial keratotomy, including related procedures designed to surgically correct refractive errors except as provided in the Covered Benefits section of the Group Health Insurance Certificate.

§4.28 No benefits will be paid for Services in connection with surgery for the purpose of diagnosing or correcting errors in refraction

§4.29 No benefits will be paid in connection with any injuries sustained while the Covered Person is operating any wheeled vehicle during an organized, off-road, competitive sporting event.

§4.30 No benefits will be paid for personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies.

§4.31 No benefits will be paid for hypnotherapy.

§4.32 No benefits will be paid for religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.

§4.33 No benefits will be paid for cosmetic Surgery or other services intended primarily to improve the Member's appearance or treatment relating to the consequences of, or as a result of, Cosmetic Surgery. This exclusion does not apply to:

4.33.1 Medically Necessary reconstructive surgery as described in the Covered Benefits sections Mastectomy and Reconstructive Breast Surgery or Reconstructive Surgery.

4.33.2 surgery to correct the results of injuries causing an impairment.

4.33.3 surgery as a continuation of a staged reconstruction procedure, including but not limited to post-mastectomy reconstruction;

4.33.4 surgery to correct congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.

§4.34 No benefits will be paid for routine foot/hand care, including routine reduction of nails, calluses and corns.

§4.35 Except as otherwise provided in this agreement, no benefit will be paid for specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.

§4.36 No benefits will be paid for Services and supplies associated with growth hormone treatment unless the Covered Person is proven to have growth hormone deficiency using accepted stimulated growth hormone analyses and also shows an accelerated growth response to growth hormone treatment. Under no circumstances will growth hormone treatment be covered to treat short stature in the absence of proven growth hormone deficiency.

§4.37 No benefits will be paid for Services and supplies provided for liposuction.

§4.38 No benefits will be paid for weight reduction programs, or dietary supplements, except as pre-authorized by Company for the Medically Necessary treatment of morbid obesity.

§4.39 No benefits will be paid for any drug, food substitute or supplement or any other product, which is primarily for weight reduction unless medically necessary.

§4.40 Except as provided in this Agreement, or unless medically necessary for the treatment of Morbid Obesity or other disease, no benefit will be paid for gastric bypass, stapling or reversal if for the purpose of weight reduction or aesthetic purposes.

§4.41 No benefits will be paid for surgical operations, procedures or treatment of obesity, except when pre-authorized by Company.

§4.42 No benefits will be paid for the treatment of male or female Infertility, including but not limited to:

§4.42.1 The purchase of donor sperm and any charges for the storage of sperm;

§4.42.2 The purchase of donor eggs and any charge associated with care of the donor required for donor egg retrievals or transfers or gestational carriers;

§4.42.3 Charges associated with cryopreservation or storage of cryopreserved embryos (e.g. office, hospital, ultrasounds, laboratory tests, etc.);

§4.42.4 Home ovulation prediction kits;

§4.42.5 Injectable Infertility medications, including but not limited to, menotropins, hCG, GnRH agonists, IVIG;

§4.42.6 Artificial Insemination, including in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and intracytoplasmic sperm injection (ICSI), and any advanced reproductive technology ("ART") procedures or services related to such procedures;

§4.42.7 Any charges associated with care required for ART (e.g., office, Hospital, ultrasounds, laboratory tests, etc.);

§4.42.8 Donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;

§4.42.9 Any charge associated with a frozen embryo transfer including but not limited to thawing charges;

§4.42.10 Reversal of sterilization surgery; and

§4.42.11 Any charges associated with obtaining sperm for ART procedures.

§4.43 Except as provided in this Agreement, no benefits will be paid for the purchase or rental of durable or disposable medical equipment and supplies, other than for equipment and supplies used in a Hospital or Skilled Nursing Facility, or in conjunction with an approved Hospital or Skilled Nursing Facility confinement, or items covered as preventive care under well-women coverage such as breastfeeding supplies in accordance with reasonable medical management techniques, or as otherwise noted in the Agreement.

§4.44 No benefits will be paid for household equipment, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbed, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Member's house or place of business, and adjustments to vehicles.

§4.45 No benefits will be paid for outpatient supplies (except diabetic supplies), including but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, and elastic stockings.

§4.46 No benefits will be paid for Services and supplies provided for penile implants of any type.

§4.47 No benefits will be paid for Services and supplies to correct sexual dysfunction.

§4.48 Except as specifically provided, if a benefit is excluded, all Hospital, surgical, medical treatments, prescription drugs, laboratory services, and x-rays in relation to the excluded benefits are also excluded as of the time it is determined that the benefit is excluded.

§4.49 Except as specifically provided in this Agreement, no benefits will be provided for Services and supplies not ordered by a Physician or not Medically Necessary.

§4.50 No benefits will be paid for temporomandibular joint disorder treatment (TMJ) including treatment performed by prosthesis placed directly on the teeth except as covered in the Covered Benefits Section

§4.51 Except as specifically provided in this Agreement, no benefits will be paid for corrective appliances, artificial aids and durable equipment.

§4.52 No benefits will be paid for Services for which the Covered Person or Subscriber is not legally obligated to pay.

§4.53 No benefit will be paid for ambulance services when used for routine and convenience transportation to receive outpatient or inpatient services, unless deemed medically necessary with prior authorization obtained from Company.

§4.54 Elective or voluntary enhancement procedures, surgeries, services, supplies and medications including, but not limited to, hair growth, hair removal, hair analysis, sexual performance, athletic performance, anti-aging, and mental performance, even if prescribed by a Physician.

§4.55 No benefits will be paid for hospital take-home drugs.

§4.56 No benefits will be paid for fees for any missed appointments or voluntary transfer of records as requested by the Covered Person.

§4.57 No benefits will be paid for educational services. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, are not covered.

§4.58 No benefits will be paid for Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition.

§4.59 No benefits will be paid for Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms or whether providing or receiving the Service.

§4.60 No benefits will be paid for non-medically necessary services, including but not limited to, those services and supplies:

- 4.60.1 Which are not Medically Necessary, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;
- 4.60.2 That do not require the technical skills of a medical, mental health or a dental professional;
- 4.60.3 Furnished mainly for the personal comfort or convenience of the Member, or any person who cares for the Member, or any person who is part of the Member's family, or any Provider;
- 4.60.4 Furnished solely because the Member is an inpatient on any day in which the Member's disease or injury could safely and adequately be diagnosed or treated while not confined;
- 4.60.5 Furnished solely because of the setting if the service or supply could safely and adequately be furnished in a Physician's or a dentist's office or other less costly setting.

§4.19 §4.61 As required by HIPAA, no source-of-injury exclusion, such as exclusion 4.29 for off-road sporting events, will apply if the accident resulted from an act of domestic violence or a medical condition (including both physical and mental health conditions).

ARTICLE 5

General Terms and Conditions

§5.1 Eligibility. An individual is eligible for Enrollment and benefits only if he or she satisfies the definition of Covered Person and has not previously had coverage under the Plan which was terminated for cause.

§5.2 Dependent. A Dependent is either a:

5.2.1 Spouse. The Spouse of the Subscriber includes: (i) a lawful wedded spouse; or (ii) a divorced spouse where there is an order issued by a court having jurisdiction over the parties that the Subscriber continue to provide such spouse coverage under this Plan, provided that no Subscriber can enroll more than one (1) person as a spouse at a time unless one spouse is covered pursuant to a court order.

5.2.2 Domestic Partner. The Domestic Partner of the Subscriber shall be defined as a person who: (1) is 18 years of age or older; (2) is of the same or opposite sex as the Subscriber; (3) is in an exclusive mutually committed relationship with the Subscriber and intends to remain the Subscriber's sole domestic partner; (4) is not married to any other person; (5) is not related to the Subscriber by blood to a degree that would prohibit marriage; and (6) has cohabitated with the Subscriber for the two (2) consecutive years immediately preceding the proposed Enrollment.

5.2.3 Children. The following are eligible for coverage as children under the Plan.

5.2.3.1 Subscriber's biological or adopted children or children placed for adoption. Eligible children include the Subscriber's biological or adopted children or children placed with the Subscriber for adoption by the Subscriber, and children under legal guardianship of the Subscriber; and children of the Subscriber's lawfully married Spouse. The Plan may not deny enrollment of a child on the grounds that the child is not claimed as a Dependent on the Subscriber's Guam Tax Return or on the grounds that the child does not reside with the Subscriber or in the Plan's Service Area. If a Subscriber is required, by a court or administrative order, to provide health care for a child, as defined above, the Plan shall permit the Subscriber to enroll, under family coverage, the child and himself/herself, provided the child is otherwise eligible, without regard to any open enrollment season or open enrollment restriction;; or

5.2.3.2 Incapacitated child. An unmarried, dependent biological child, adopted child, or child placed for adoption with the Subscriber or the Subscriber's lawfully wedded spouse, which child is over the age of twenty-six (26) years, and incapable of self-sustaining employment by reason of mental retardation or physical handicap, and is therefore primarily dependent on the Subscriber for support and maintenance and has been continuously dependent since reaching age twenty-six (26); or

5.2.3.3 Child under court order. A biological child, adopted child, or child placed for adoption with the Subscriber who does not reside with the Subscriber, provided that a court having jurisdiction over the parties and the subject matter has issued an order requiring the Subscriber to provide such child with health coverage. If such coverage is effected through this Plan, such coverage shall continue only so long as the order remains in effect, and such child is and remains otherwise eligible; or

5.2.3.4 Child of Domestic Partner. A child of an eligible Domestic Partner who is not the biological child, adopted child or child placed with the Subscriber for adoption if (i) a court having jurisdiction over the parties and the subject matter has issued an order granting the guardianship of such child to the Subscriber; and (ii) such child is and remains otherwise eligible; or

5.2.3.5 Child under guardianship. A child for whom (i) a court having jurisdiction over the parties has issued an order granting the guardianship of such child to the Subscriber; and (ii) such child is and remains otherwise eligible. Children under guardianship will only remain eligible until the guardianship terminates but no later than up to age 26. An unborn child does not qualify as a child under guardianship. Any such retroactive termination shall be handled in compliance with PPACA regulations.

5.2.3.6 Adult Child up to Age 26. As required by PPACA, a child having a relationship to the Subscriber or the Subscriber's lawfully married spouse as provided in section 5.2.1 and 5.2.3.1 shall be eligible until the child's 26th birthday, regardless of whether the child is married, dependent on the Subscriber, or a student. The spouse of a married adult child shall not be eligible and the child of an adult child shall not be eligible for coverage under this section 5.2.3.6. The adult child shall receive coverage on the same terms as other children except for any special rights designed for individuals below the age of 19 and any other differences permitted by PPACA. Any adult child who was previously covered by the plan and excluded due to age, marital status, or cessation of dependency or student status, and any adult child who was previously denied coverage due to age, marital status, or lack of dependency or student status, shall be notified of the ability to enroll under this provision, and shall be given at least 30 days to elect to enroll. Any such child electing to enroll under this provision shall be treated as a HIPAA special enrollee.

5.2.4 Child Not Denied Coverage. In accordance with Title 10 GCA Section 95101, and notwithstanding any other provision of this Agreement, no child whose parent is a Subscriber or Spouse shall be denied coverage solely for any of the following reasons:

5.2.4.1 The child was born out of wedlock.

5.2.4.2 The child is not claimed as a dependent on the parent's Guam tax return.

5.2.4.3 The child does not reside with the parent or in the Service Area.

5.2.4.4 The child has a pre-existing or excluded medical condition.

5.2.4.5 The child is adopted or the subject of adoption proceedings.

§5.3 Residency Requirement. Except as otherwise specifically stated in this Agreement, Enrollment in the Plan shall be limited to only those Covered Persons who are Domiciled in the Service Area and do not reside out of the Service Area for more than 182 days per Plan Year. Company shall be entitled to prior notice from the Covered Person concerning his/her residency status and the failure of the Covered Person to provide this prior notice may result in a denial of benefits under this Agreement. Company shall also be entitled to require substantiation from a Covered Person to determine the Covered Person's Domicile and may deny benefits under this Agreement for lack thereof. Covered Persons outside the Service Area must coordinate their care and obtain Prior Authorization from the Company for Services, excluding Emergency services. For a Covered Person who is Domiciled in the Service Area, time spent receiving continuous medical Services out of the Service Area shall not count toward the 182 day maximum provided the receipt of such Services precludes returning to the Service Area. Further, time spent by a parent or spouse of such Covered Person shall not count toward the 182 day maximum, provided the parent or spouse is providing necessary assistance to the Covered Person and further provided that under no circumstance can there be more than one such caregiver hereunder for any incident out of the Service Area. Company shall use its best efforts, to include making available written forms and materials, to inform Subscribers of the requirements of this Section during enrollment period, in its marketing materials and on its website.

§5.4 Enrollment documentation. The following documents are required prior to enrolling the following Dependents:

5.4.1 Overage child. For a Dependent child over the limiting age:

5.4.1.1 Eligible Dependent Children residing outside the Service Area are eligible for coverage up to but not including their twenty-sixth (26th) birthday, provided proof of eligibility such as but not limited to a legal birth certificate being submitted to the Company. The Eligible Dependent Children must select a Participating Provider as provided in §2.1.1 of this Certificate. To obtain coverage, all care must be provided or coordinated with the Participating Primary Care Provider and Prior Authorization must be obtained from the Company for Specialty and Hospital Services excluding Emergency and covered Primary Care Services.

5.4.1.2 Proof of incapacity. For continuing dependency resulting from incapacity, satisfactory proof of such continuing incapacity and dependency, within thirty-one (31) days of such child attaining the limiting age and annually thereafter.

5.4.1.3 Child under court order. For a Dependent child under court order requiring the Subscriber to provide health coverage for such child, a certified copy of the court order requiring such coverage.

5.4.1.4 Child under guardianship. For a Dependent child under guardianship, a certified copy of the court order granting the guardianship of such to the Subscriber.

5.4.2 Non-resident child. For a Dependent child not residing with the Subscriber, and is not under court order and is not covered as an adult child up to age 26, and is over the of 26, is a dependent of the Subscriber and an incapacitated child as stated under Section 5.2.3.2:

5.4.2.1 Affidavit. A notarized affidavit of support executed by the Subscriber.

5.4.2.2 Any other documentation as required by the Company to show the Dependent Child's relationship to Subscriber.

5.4.3 Child under court order. For a Dependent child under court order requiring the Subscriber to provide health coverage for such child, a certified copy of the court order requiring such coverage.

5.4.4 Child under guardianship. For a Dependent child of an eligible Domestic Partner and a Dependent child otherwise under guardianship, a certified copy of the court order granting the guardianship of such child to the Subscriber. The Subscriber shall also be required to provide such evidence as to the qualification of the Dependent for legal guardianship as Company may require.

5.4.5 Domestic Partner of the Subscriber. A Domestic Partner may only be enrolled during an open enrollment period. At the time that a Subscriber attempts to enroll a Domestic Partner, the Company may require an affidavit from said Subscriber and Domestic Partner in order to establish the person's eligibility as a Domestic Partner. If the affidavit contains any material factual matters which later prove to be untrue as a result of fraud or intentional misrepresentation of material fact, the Domestic Partner shall be retroactively terminated to the effective date of the Plan, and the Subscriber and Domestic Partner shall be liable to reimburse the Company for the costs of all Services which have been provided for the Domestic Partner. If any material factual matters were not the result of fraud or intentional misrepresentation of material fact, termination of coverage of the Domestic Partner shall be prospective. Domestic Partner of the Subscriber.

5.4.5.1 Affidavit. A notarized affidavit executed by both the Subscriber and the Domestic Partner in a form acceptable to the Company verifying, among other facts, that the Subscriber and Domestic Partner have cohabitated for the two (2) consecutive years immediately preceding the proposed Enrollment of such Domestic Partner.

5.4.5.2 Proof of eligibility. Satisfactory proof to the Company that the Domestic Partner and Subscriber meet the requirements of a domestic partnership as defined for purposes of this Agreement.

§5.5 Institutionalized applicant. Any individual shall be entitled to the full benefits of this Plan beginning on his or her effective date regardless of any pre-existing medical condition and regardless of whether he or she is confined as an inpatient in any institution. In the event the individual is confined in an inpatient facility covered under this Agreement and incurring costs covered under this Plan, Company will make best efforts to coordinate with the individual's prior carrier, if any, to minimize disruption in the individual's medical care and to minimize cost to the Plan.

§5.6 Enrollment.

5.6.1 Enrollment during an open Enrollment period. An eligible individual may enroll in the Plan and may cause his or her Dependents to become Enrolled, during an open Enrollment period.

5.6.2 Enrollment after open Enrollment period. Persons becoming eligible for Enrollment after completion of the open Enrollment period under this Agreement may elect to enroll within thirty (30) days of the date of first becoming eligible.

5.6.3 After thirty (30) Day Enrollment.

5.6.3.1 Subscriber. Subject to §5.6.3.3, an individual eligible to enroll as a Subscriber who does not make written election for Enrollment within thirty (30) days after first becoming eligible shall not be permitted to enroll hereunder until the next open Enrollment period unless entitled to special enrollment rights under HIPAA or PPACA.

5.6.3.2 Dependents. Subject to §5.6.3.3, a Subscriber with Dependents eligible for Enrollment who does not make written election for Enrollment of such Dependents within thirty (30) days after their first becoming eligible shall not be permitted to enroll such Dependents hereunder until the next open Enrollment period unless entitled to special enrollment rights under HIPAA or PPACA.

5.6.3.3 HIPAA and PPACA Enrollment requirements. If an individual eligible to Enroll as a Subscriber loses other employer coverage or acquires a Dependent through marriage, birth, adoption of a child under nineteen (19) years of age, or placement for adoption of a child under nineteen (19) years of age, then the special Enrollment requirements of HIPAA may be applicable. If a Subscriber becomes eligible for a HIPAA special enrollment, such Subscriber and Spouse and children, if applicable, shall be entitled to change from Class I or Class II to Class III during such special Enrollment. A child previously excluded, or whose coverage ceased, because of age, shall have special enrollment rights to enter or reenter the Plan upon receipt of notice of the right to do so, to the extent required by Section 2714 of the PHSA, as added by PPACA, and the regulations thereunder.

§5.7 Commencement of coverage. After fulfilling all conditions of Enrollment as set out in this Agreement, coverage under the Plan shall commence:

5.7.1 **Previously Enrolled.** As of the Effective Date of this Agreement, for a Subscriber and his or her Covered Dependents who are Enrolled on such Effective Date.

5.7.2 **Not yet Enrolled.** As of the first day following the pay period in which the individual satisfies the Enrollment requirements set forth in this Agreement and Company becomes entitled to receive the appropriate Premium for a Subscriber and his or her Covered Dependents who become Enrolled subsequent to the Effective Date of this Agreement.

5.7.3 **Except as provided in §5.8,** coverage of a Dependent of a Subscriber who becomes eligible after such Subscriber has been Enrolled hereunder shall commence as of the first day of the pay period following the timely filing of an application for Enrollment and liability for the appropriate Premium accrues. Coverage for a child born, adopted (if under nineteen (19) years), placed for adoption (if under nineteen (19) years), or for whom legal guardianship has taken place after the Subscriber has been enrolled hereunder, shall commence from the date of birth, date of adoption, date of placement for adoption, or for child under guardianship, from the date at which custody commences, whichever is applicable; provided that the Subscriber applies to Enroll the child within the first thirty (30) days of that date and the applicable Premium is paid.

5.7.4 **Open Enrollment period.** For any eligible individual and his or her eligible Dependents who apply for Enrollment or re-Enrollment during GovGuam's open Enrollment period, coverage shall commence as of the Plan effective date first following the open Enrollment.

§5.8 Continuing Enrollment. Subscribers and Covered Dependents enrolled under this Plan on the last day of a Plan Year shall be automatically enrolled for the following Plan Year unless they change to some Other Plan during open Enrollment or unless this Plan is not renewed.

§5.9 Medical term. Covered Persons must continue medical coverage under this Agreement for a minimum of twelve (12) months or for the balance of the Plan Year, except when terminating GovGuam employment, or when termination of Enrollment is approved by GovGuam's Director of Administration and by Company. A rate increase during the Plan Year is not grounds for disenrollment.

§5.10 Dental eligibility and term. Covered Persons may enroll in the Company's dental plan only if they are enrolled in Company's medical plan. Covered Persons in the medical and dental Plan must continue their medical and dental coverage under this Agreement for a minimum of twelve (12) months or for the balance of the Plan Year, except when terminating GovGuam employment, or when termination of Enrollment is approved by GovGuam's Director of Administration and by Company. A rate increase during the Plan Year is not grounds for disenrollment.

§5.11 Leave without pay, reduction in force, sabbatical and related status. A Subscriber, who enters the status with GovGuam of leave without pay, sabbatical leave, educational leave of absence or a faculty exchange program as approved by GovGuam, or is laid off due to a reduction in the workplace by GovGuam, and all enrolled Dependents of such Subscriber, can remain covered under this Agreement if such Subscriber self-pays both the Subscriber's and GovGuam's share of the premium for such coverage directly to the Company. Within 10 business days following commencement of the leave without pay, reduction in force, sabbatical and related status, the Subscriber must provide Company (i) proof, in a form satisfactory to Company, that he or she has been approved by GovGuam for such status and (ii) written notice of his or her intention to continue coverage during the leave. Such notice must be accompanied by the first month's Premium. Subsequent Premium payments must be made by the 15th day of the month preceding the month for which coverage is being paid. Subscribers who do not make their Premium payments when due shall have their coverage terminated as of the last day for which payment was made and shall not be allowed to reenroll in the Plan until the next Enrollment period.

following the return to work. In no case, however, can such continued membership in the Plan extend for a period in excess of 12 months. If Company does not receive the full amount of Premium due at least 15 days in advance, it shall make a good faith effort to notify the Subscriber that Coverage shall terminate on the last day of the month for which Premium was paid. Notwithstanding the aforesaid, laid off Subscribers may not remain in the Plan beyond the end of the current Plan Year.

5.11.1 Notwithstanding the aforesaid, if the leave is taken pursuant to the Family and Medical Leave Act of 1993, Company shall fully cooperate in assisting GovGuam in complying with this Act.

5.11.2 Active employees required to live out of the Service Area pursuant to their employment by GovGuam or GovGuam sponsored training status and their eligible Dependents shall be eligible for coverage under the Plan.

§5.12 Military leave. Company shall be given prior written notice if a Subscriber shall take a military leave of absence ("Military Leave"). Coverage for such Subscriber shall continue for the shorter of eighteen (18) months or the duration of the Military Leave up to a cumulative length of no longer than five (5) years unless otherwise agreed upon with Company, provided Premiums are paid. Even if the Subscriber elects not to continue coverage for himself or herself or any Dependent during the Subscriber's Military Service, the Subscriber and all Dependents shall be eligible to re-enroll immediately after such Military Leave terminates, without a waiting period or health statement, upon the Subscriber's return to employment by GovGuam if the Subscriber satisfies applicable requirements that were in the Plan prior to such Military Leave and no discharge from Military Service is less than fully honorable. Company shall not provide coverage for any Injury or Illness determined by the Secretary of Veterans' Affairs to have been incurred or aggravated during Military Service. The provisions of this paragraph are notwithstanding any other section of this Agreement.

§5.13 Reduction in hours. If a Subscriber's work hours are reduced below 30 per week due to a GovGuam cost-saving program, such Subscriber and his/her enrolled Dependents shall be eligible to remain in the Plan in accordance with all other terms of the Plan. Alternatively, such Subscriber shall have the option to disenroll within 30 days of the effective date on which the reduction in hours occurs provided that, within 10 business days following such effective date, the Subscriber shall have provided notice to Company of his/her intent to disenroll. Further, he/she shall not be eligible to reenroll until a future open Enrollment or until his/her work hours are increased to at least 30 hours per week.

§5.14 Procedure upon retirement. A newly retired Subscriber, and all of his/her enrolled Dependents, may remain in the Plan by paying the full amount of the Premium due to the Company, in accordance with the time frames applicable to GovGuam, until such Subscriber's status change from active to retired employee is fully processed by GovGuam. However, within 10 business days of separation of active employment, GovGuam must certify in writing to the Company that such Subscriber is eligible for retiree health coverage. Further, within 10 business days of separation from active employment, the Subscriber must provide the Company with written notice of his/her separation from active employment and intention to continue coverage.

§5.15 Coordination of Benefits. If a Covered Person receives any medical, Surgical, Hospital or other Services entitling that Covered Person to the payment of benefits under this Agreement and such Services are also covered or payable under any Other Plan, which, for purposes of this section, shall include Medicare Parts A and B and any motor vehicle insurance policy or contract, then the benefits of this Plan and each other plan shall be appropriately coordinated and adjusted so that such benefits shall not exceed one hundred percent (100%) of Eligible Charges. Integration or coordination of benefits with Medicare shall be done on a "Carve Out" or "Benefit Offset" basis. When any Other Plan provides benefits in the form of Services rather than cash payments, the reasonable cash value of such Services rendered shall be deemed to be both an allowable expense and a benefit paid. The coordination and adjustment of benefits shall be determined as follows:

5.15.1 The plan under which the Covered Person is a Subscriber is primary.

5.15.2 In the case of a Dependent child, the plan of the parent whose birthday occurs earlier in the calendar year is the primary carrier. If both parents have the same birthday, then the plan in which the Covered Person has been enrolled for the longest continuous time pays first. However, other rules apply if a claim is made for an insured dependent child whose parents are separated or divorced. If the parent with custody of the child has not remarried, the plans shall pay in this order: first, any plan in which the child is insured as a Dependent of the parent who has custody; and second, any plan in which the child is insured as a Dependent of the parent who does not have custody.

If the parent with custody of the child has remarried, the plans shall pay in this order: first, any plan in which the child is insured as a dependent of the parent who has custody; second, any plan in which the child is insured as the dependent of the stepparent; and third, any plan in which the child is insured as the dependent of the parent who does not have custody.

These rules do not apply when a court decree fixes the responsibility for the health Services costs of a child whose parents have separated or divorced. Any plan in which the child is insured as the dependent of a parent with this legal responsibility shall always pay first.

If the order of payment is unclear, the National Association of Insurance Commissioners' (NAIC) model shall apply.

5.15.3 In no event shall coordination of benefits require Company to: (i) make any payment which would exceed the amount for which it would be liable under this Plan if a Covered Person were not eligible to receive benefits from any other plan; or (ii) pay the excessive, unnecessary or unreasonable portion of any charge or expense. A Covered Person who is also enrolled in one or more of Company's other plans shall be entitled to receive benefits from all of such plans not to exceed one hundred percent (100%) of Eligible Charges.

§5.16 Subrogation, Right of Reimbursement and Right of Recovery. The Company reserves the "right of subrogation" the "right of reimbursement" and the "right of recovery," in the event of an illness, injury or condition caused by a third party or with respect to which a "first party payor" has liability, for which the Company has paid or is being requested to pay benefits under this Plan or for which the Company chooses to advance benefits as provided in this Section.

5.16.1 Definitions.

5.16.1.1 As used throughout this provision, the term "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to or for the benefit of a Covered Person due to a Covered Person's injury, illness or condition. The term "Responsible Party" includes (without limitation) the liability insurer of such party or any insurance coverage.

5.16.1.2 For purposes of this provision, the term "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured or underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

5.16.1.3 For purposes of this provision, a "Covered Person" includes anyone on whose behalf the Company pays or provides any benefit including, but not limited to, the participating employee or former employee and any minor child or other dependent of any such employee, and any person who acts or

holds funds on behalf of such an employee, former employee or dependent. For example, if an injured Covered Person is a minor child, and the child's parents receive a recovery for the child, "Covered Person" for purposes of the Company's right to repayment shall include a right for the Company to recover from the parents or other party receiving or holding such recovery on behalf of the child

5.16.1.4 For the purposes of this section, a first party payor is a person or company with whom a Covered Person has either a contractual relationship, is in privity with a non-responsible party through whom benefits are available that are related to the Illness or Injury, or for whom benefits are otherwise available, regarding the Illness or Injury but regardless of fault, such as workers' compensation coverage, uninsured motorist coverage and no-fault motorist coverage.

5.16.2 **Subrogation.** Immediately upon paying or providing any benefit under the Government of Guam Health Insurance Plan, and as permitted by Guam's laws, the Company shall be subrogated to all rights of recovery that a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injury, illness, or condition to the full extent of benefits provided or to be provided by the Company.

5.16.3 **Reimbursement.** In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness, or condition, the Company has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Company has paid and will pay as a result of that injury, illness, or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

5.16.4 **Right of Recovery.** The Company also has a "right of recovery," in that it may choose to take action to recover the amount of all claims paid to or on behalf of a Covered Person from the third party, or from any insurer or other party that is or may be liable for damages related to the third party's actions.

5.16.5 **Constructive Trust.** By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Company, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness, or condition, he or she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Company and the Plan, and will give the Company rights to recover equitable and money damages from the Covered Person.

5.16.6 **Lien Rights.** The Company shall automatically have a lien to the extent of benefits paid by the Company for treatment of the illness, injury, or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise related to treatment for any illness, injury, or condition for which the Company paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Company including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the Company. The Company may file this lien with the third party, third party's agent, any insurance company, first party payor or the court in which any action is filed, to assure that the lien is satisfied from any such recovery. Further, the Plan reserves the right to notify the Responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

5.16.7 First-Priority Claim. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Company, the Covered Person acknowledges that the Company's recovery rights are the first priority claim against all Responsible Parties and are to be paid to the Company before any other claim for the Covered Person's damages. The Company shall be entitled to full reimbursement on a first-dollar basis from any and all payments from each and every Responsible Party, even if such payment to the Company will result in a recovery to the Covered Person that is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Company is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

5.16.8 Applicability to All Settlements and Judgments. The terms of this entire subrogation, reimbursement and right of recovery provision shall apply to each and every settlement or judgment related to the injury, illness or condition of the Covered Person, and the Company is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies any medical benefit the Company provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Company is entitled to recover from any and all settlements or judgments, including (without limitation) those designated as pain and suffering, non-economic damages, and/or general damages only.

5.16.9 Cooperation. The Covered Person shall fully cooperate with the Company's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Company within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by the Covered Person. The Covered Person and his or her agents shall provide all information requested by the Company or the Plan, or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Company may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person. The Covered Person shall do nothing to prejudice the Company's subrogation or recovery interest or to prejudice the Company's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

5.16.10 Right of Investigation. The Company has the right to conduct an investigation regarding the injury, illness, or condition of any Covered Person to or for the benefit of whom the Company pays benefits under the Plan to identify any Responsible Party. Each Covered Person receiving benefits under the Plan acknowledges or is deemed to acknowledge that the Company has such right of investigation.

5.16.11 Interpretation. In the event that any claim is made that any part of this subrogation, reimbursement and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, any and all questions shall be resolved in accordance with the most recent US Supreme Court decision on ERISA cases on health insurance subrogation.

5.16.12 Jurisdiction. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Company, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Company may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

5.16.13 After expenses incurred by the Company in obtaining any recovery from, on behalf of or related to such third party, the net amount recovered must be divided proportionately with the Covered Person to allow the Covered Person to recover a proportionate share of any deductible for which the insured was responsible.

5.16.14 **Benefit Exclusion or Delay.** In cases where third party or first party payor liability is being pursued, and upon the execution and delivery to Company of all documents required by it, to secure its rights of subrogation, reimbursement and right of recovery entitlements, as provided in this Section 5.16, the Company may pay benefits in connection with such Injury or Illness if it is satisfied that its subrogation, reimbursement and recovery rights are being upheld and shall be repaid only from the proceeds (beginning with the first proceeds) of any and all recoveries, if any, from or on behalf of such third party or from any first party payor. As security for such repayment, the Company shall have a lien, as provided in this Section 5.16, against any and all such recoveries to the extent of the amount advanced to the Covered Person by Company.

5.16.15 **PPACA Compliance.** In the event that any applicable provision of PPACA prohibits the application of any provision of this Section 5.16, the section shall be deemed modified to the extent necessary to comply with PPACA.

§5.17 **Covered Person eligible for Medicare.** The Plan shall pay its benefits pursuant to this Agreement before Medicare if (i) the Subscriber is an active, full-time employee of GovGuam or his or her Spouse is a Covered Person and the Subscriber or Spouse who is a Covered Person is sixty-five (65) or older; or (ii) the Subscriber or Spouse who is a Covered Person is under age sixty-five (65) and is in the Medicare waiting period during which he or she or his or her Spouse is receiving treatment for end-stage renal disease (ESRD); or (iii) for services in the Philippines or other countries outside of Guam or the United States as provided in this section.

If any Covered Person, including disabled active individuals as defined in the Omnibus Budget Reconciliation Act of 1993, incurs expense for benefits covered under the Plan and for which the Covered Person is eligible for and entitled to benefits under Medicare, then the Plan, where primary carrier, shall pay to the full limit of its coverage before Medicare assumes coverage. The Covered Person shall have covered benefits equal to the greater of the two plans' benefits.

If any Covered Person, for whom Medicare is or would be primary, is eligible for but not enrolled in the entire Medicare program but is receiving income benefits from Social Security, the Plan shall provide no benefits on behalf of that person. However, under no circumstances shall anyone be required to enroll in Medicare in order to receive benefits under the Plan, unless the Medicare programs are available at no cost. Eligible Persons receiving Social Security may be required to enroll in Medicare Part A in order to receive benefits under the Plan, unless Medicare Part A is available to her or him at no cost but shall be required to enroll in Part B, subject to the Government of Guam or some other entity paying the Part B premium.

For a Covered Person enrolled in Medicare Parts A and B and where Medicare is primary, Company shall pay the co-payments, deductibles, and co-insurance required by Medicare and treat Covered Person as having met the Out-of-Pocket maximum under the plan for purpose of receiving benefits under this Agreement.

For a Covered Person, for whom Medicare is or would be primary if the covered services are received in the United States or its territories, the Plan shall pay to the full limit of its coverage as primary provider, when covered services are received at a Participating Provider, in the Philippines or other country outside of Guam or the United States and when prior authorization for the services is received from the Company. The preceding sentence shall not apply to emergency or nonemergency hospital services provided to the Covered Person that are covered by Medicare because the hospital outside of

Guam or the United States is closer to, and substantially more accessible from, the retiree's Guam residence than the nearest participating US hospital which is adequately equipped to deal with and available to provide treatment of the illness or injury, and to any physician and ambulance services furnished in connection with emergency or nonemergency hospital services.

§5.18 Incarcerated Benefits. The Plan is secondary payer for services furnished to individuals in the custody of penal authorities. The state (or other government component which operates the prison) in which the beneficiary resides is responsible for all medical costs incurred.

§5.19 Release of medical information. As a condition to the receipt of Plan benefits, each Covered Person authorizes Company to use and obtain information about his or her medical history, medical condition and the Services provided to him or her as may be necessary in connection with the administration of this Agreement. Information from medical records of Covered Persons and information received from Physicians or Hospitals arising from the Physician-patient relationship shall be kept confidential and shall only be disclosed with the consent of the Covered Person and in accordance with applicable law.

§5.20 No warranty of Service.

5.20.1 Company is not liable for the negligence or other, wrongful act or omission of any Physician, Hospital, Hospital employee or other Provider, or for any act or omission of any Covered Person, except to the extent that said negligence or other wrongful act or omission is committed by a Company, employee or servant acting within the course and scope of their employment at the FHP Clinic.

5.20.2 Company does not guarantee the availability of or undertake to provide any Services of any third party.

§5.21 Termination for cause. Company may terminate a Covered Person from the Plan for:

5.21.1 Misuse of card. A Covered Person knowingly allowing his or her Plan identity card to be used by another person or falsely representing the relation between himself or herself and another in order that the other person can obtain Services hereunder; or

5.21.2 Non-payment. A Covered Person's failure to pay or arrange to pay applicable Deductibles, Co-Payments, or Co-Insurance as soon as practicable, and in no case later than the next Enrollment period.

5.21.3 To the extent required by PPACA, terminations for cause (other than for non-payment of premiums) shall be handled as required by the applicable PPACA Claims Procedure Requirements provided in §6.7 and as reflected in the Company's Appeal Procedures attached as Exhibit F.

§5.22 Termination other than for cause. Other terminations of benefits, not for cause, are as follows:

5.22.1 Termination by a Covered Person. Except as otherwise provided in this Agreement or applicable law, if the Covered Person terminates his or her rights under this Agreement then all rights to benefits shall cease as of the effective date of such termination. If a Subscriber's coverage so terminates, his or her Covered Dependents' coverage shall terminate on the same date. However, Company shall pay Eligible Charges for all Covered Services incurred prior to the date of termination.

5.22.2 Marriage terminated or no longer eligible spouse. If the spouse of a Subscriber ceases to be a Spouse as defined herein, coverage for such person under this Agreement shall terminate on the first (1st) day of the pay period following termination of eligibility.

5.22.3 Domestic Partnership terminated. If the domestic partner of a subscriber ceases to be a Domestic Partner as defined herein, coverage for such person under this Agreement shall terminate on the first (1st) day of the pay period following termination of eligibility.

5.22.4 Children no longer eligible as Dependents. Coverage shall terminate as to a Dependent child who attains age twenty-six (26), or who enters the Military Service, on the date of such occurrence. However, a Dependent child who has attained the limiting age (26), and who is incapable of self-sustaining employment by reason of developmental disability or physical handicap, and who is primarily dependent upon the Subscriber for support and maintenance, may continue to be covered under this Plan as an enrolled Dependent during the continued disability or handicap provided proof of such incapacity and dependency is furnished to Company within thirty (30) days of the child's attainment of the limiting age and annually thereafter.

5.22.5 Rebate of Premium. In the event of termination of coverage, GovGuam or the Subscriber, as applicable, shall receive a pro rata rebate of the Premium paid to Company for such Covered Person.

5.22.6 Effective date of termination. Except as otherwise provided herein, termination of coverage shall take effect on the first (1st) day of the pay period following the event causing termination.

5.22.7 To the extent required by PPACA, disputed terminations (other than for non-payment of premiums) shall be handled as required by the applicable PPACA claims procedure rules. A Covered Person can appeal a disputed termination pursuant to the PPACA Claims Procedure for internal and external review appeals provided in §6.7 and set out and reflected in Exhibit F.

5.22.8 HIPAA compliance. Company shall provide the certifications required by HIPAA for terminated Subscribers and their Covered Dependents, upon notification by GovGuam of the Subscriber's termination. Company shall also provide certifications for all other terminated Covered Persons, such as Dependent children reaching the limiting age, divorce of a Spouse, or end of domestic partnership, without notification by GovGuam, but after receipt of actual notice of the triggering event.

§5.23 Grievance Procedures. The Grievance Procedure is not applicable to adverse benefit determinations, including rescission of coverage, and their appeals which are subject to PPACA Claims Procedure Requirements provided in §6.7 and reflected in the Company's Appeal Procedures attached as Exhibit F. A grievance is a formal complaint or dissatisfaction with the service received by a Covered Person. Grievance includes complaints about the quality of care or non-quality of care services at any of the Company's contracted network facilities, providers or with any administration provider/behavioral services and access to care. Non-quality of care services includes complaints about administrative services, sales processes or other marketing issues. A Covered Person and/or his or her representative may file a written grievance claim, including all relevant documentation, with the Company. The Covered Person and Company shall provide additional information or documentation, as applicable, if requested in writing.

5.23.1 Within sixty (60) days after a grievance is received by the Company, the Covered Person shall be notified in writing of the denial, partial denial or approval of the grievance.

5.23.2 If a Covered Person does not agree with the decision, then the Covered Person or the Covered Person's authorized representative may file a grievance appeal as follows:

5.23.2.1 A written grievance appeal request must be directed to the Grievance Coordinator. The request shall state all bases for the grievance appeal and be supported by all relevant information and documentation.

5.23.2.2 The Grievance Coordinator may refer grievance appeals to the medical society, the utilization department, peer review committee, or a medical specialty organization for an opinion to assist in the resolution of the grievance appeal.

5.23.2.3 Within ten (10) working days of the receipt of a grievance appeal, the Grievance Coordinator shall be available to meet with the Covered Person to discuss possible resolution of the matter and establish the time frame for review of the grievance appeal, which shall not exceed thirty (30) days.

5.23.2.4 If, after receipt of the written decision on disposition of the grievance appeal the Covered Person is not satisfied, then the Covered Person may proceed with arbitration, in which event the provisions of §5.24 shall apply.

§5.24 Notice. For purposes of service of any notice or other document under this Agreement, a Covered Person's address shall be that stated in the Enrollment materials, unless the Covered Person designates a new address by providing written notice to the Company. The address of the Company is: 415 Chalan San Antonio, Ste. 108, Tamuning, Guam 96913, unless the Company designates a new address in writing served on the Covered Person.

§5.25 Cooperation Regarding Federal Law. Company and the Government of Guam shall fully cooperate in implementing any Qualified Medical Child Support Order as defined and required by federal law. This shall include enrolling the employee, if eligible, and the relevant child, if eligible, outside a regularly scheduled open Enrollment period.

ARTICLE 6

Claims and Payment for Service

§6.1 Submission of claims. When Services are provided to a Covered Person, the Covered Person shall inform the Provider that he or she is a Covered Person of Company. In the case of a Participating Provider, the Covered Person is not responsible for filing the claim. In the case of a Non-Participating Provider, the Covered Person must file a claim for reimbursement unless the Provider agrees to file a claim on the Covered Person's behalf. Company shall not be obligated to make any payment until it receives, reviews and approves a claim for payment.

§6.2 Payment for Covered Services. Company shall make payment of claims for Covered Services directly to Participating Providers. In the case of Non-Participating Providers, the Covered Person is responsible for payment to the Provider, and payment of claims shall be made by Company directly to the Covered Person.

§6.3 Reimbursement for Services. If the Covered Person has paid for Covered Services, Company, upon submission of a complete claim by the Covered Person shall reimburse the Covered Person to the same extent that it would have directly paid the Provider of the Covered Services.

§6.4 Payment of late claims. In no event shall any payment be owed or made on any claim submitted to Company more than ninety (90) days after which the Covered Services were rendered, unless:

6.4.1 The claim is subject to coordination of benefits, Company is not the primary carrier, and the claim was submitted to the primary carrier during the twelve (12) month period; or

6.4.2 Required by law, including applicable PPACA Claims Procedure requirements.

§6.5 Proof of Payment of Deductible. Company shall require participating providers to report all payments made by members for covered services within 120 days of the date when the covered services were rendered. Company shall not credit any eligible amounts paid towards any Deductible unless proof of such payment is submitted within one hundred twenty (120) days of the date on which the Covered Services were rendered.

§6.6 Utilization review.

6.6.1 Company shall not be required to pay any claim until it determines that Services provided to a Covered Person are Covered Services.

6.6.2 Company has the right to conduct utilization review on a prospective concurrent and/or retrospective basis, subject to compliance with PPACA applicable Claims Procedure Requirements.

§6.7 PPACA Claims Procedure Requirements. Adverse benefit determinations, including rescissions of coverage, and their appeals are subject to the requirements of Section 2719 of the PHSA, as added by PPACA, and applicable regulations to include 45 CFR 147.136 and 29 CFR 2560.503-1. The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan (e.g., a rescission of coverage), and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. The Company's PPACA Claims Procedure is reflected in Exhibit F.

6.7.1 As required by PPACA, the Company shall comply with U.S. Department of Labor claims regulations applicable to health plans under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), as set forth at Section 2560.503-1 of Title 29, Code of Federal Regulations, as such regulations may be updated from time to time by the Secretary of Labor (the "ERISA Claims Regulations"). These ERISA Claims Regulations shall apply notwithstanding that the Plan is a government plan, previously not subject to ERISA's requirements, but shall be modified as follows:

6.7.1.1 An adverse benefit decision, to which the ERISA Claims Regulations shall apply, shall include a rescission, whether or not the rescission has an adverse effect on any particular benefit at that time.

6.7.1.2 In the case of a claim determination (whether adverse or not) involving urgent care, the claimant shall be notified as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan.

6.7.2 On appeal, the claimant must be allowed to review the claim file and to present evidence and testimony.

6.7.3 Other aspects of the PPACA Claims Procedure regulations shall be followed including the right of a Covered Person to file an external review within four (4) months after the Covered Person receives notice of adverse benefits determination or denial of an internal appeal from the Company.

ARTICLE 7

Dental Benefits

§7.1 Dental Benefits Available. This Article contains the Dental Benefits available to Covered Persons in the optional dental plan.

§7.2 Definitions. The definitions contained herein are supplemental to those contained elsewhere in this Agreement and apply only to Dental Benefits in the optional dental plan. The definitions contained elsewhere in this Agreement are applicable to this Article.

7.2.1 Treatment Plan. Treatment Plan means a Dentist's report of the Covered Person's dental defects, prescribing a program of treatment for the identified defects, including applicable charges.

§7.3 Maximum Allowances. The maximum dental benefit payable by the Company for each Covered Person shall be One Thousand Dollars (\$1,000) per Plan Year.

§7.4 Co-Payments for Diagnostic and Preventive Services.

7.4.1 For any Diagnostic and Preventive Services which are covered under §7.7.1 of this Agreement, Company will pay 100% of Eligible Charges if the Services are rendered by a Participating Provider.

7.4.2 For any Diagnostic and Preventive Services which are covered under §7.7.1 of this Agreement, Company will pay 70% of Eligible Charges if the Services are rendered by a Non-Participating Provider.

§7.5 Payments for Basic and Restorative Services.

7.5.1 For any Basic and Restorative Services which are covered under §7.7.2 of this Agreement, Company will pay 80% of Eligible Charges if the Services are rendered by a Participating Provider.

7.5.2 For any Basic and Restorative Services which are covered under §7.7.2 of this Agreement, Company will pay 70% of Eligible Charges if the Services are rendered by a Non-Participating Provider.

§7.6 Payments for Major and Replacement Services.

7.6.1 For any Major and Replacement Services which are covered under §7.7.3 of this Agreement, Company will pay 50% of Eligible Charges if the Services are rendered by a Participating Provider.

7.6.2 For any Major and Replacement Services, which are covered under §7.7.3 of this Agreement, Company will pay 35% of Eligible Charges if the Services are rendered by a Non-Participating Provider.

§7.7 Services Available. Subject to the other conditions contained in this Agreement, Covered Persons choosing the optional dental plan for whom Premiums have been paid shall be entitled to the following Dental Benefits:

7.7.1 Diagnostic and Preventive Services.

7.7.1.1 Examinations (including Treatment Plan) limited to once every six (6) months.

7.7.1.2 Radiographs (X-rays).

7.7.1.2.1 Full mouth series (once per 36 months).

7.7.1.2.2 Bite-wings. Maximum of four per Plan Year.

7.7.1.3 Prophylaxis (cleaning and polishing) limited to twice per Plan Year.

7.7.1.4 Topical application of fluoride (once every Plan Year for Covered Persons under the age of 19);

7.7.1.5 Study models.

7.7.1.6 Space maintainers (for Covered Persons age 15 and under). This includes adjustments within 6 months of installation.

7.7.1.7 Caries susceptibility test.

7.7.1.8 Sealants (for permanent molars of Covered Persons age 15 and under).

7.7.2 Basic and Restorative Services.

7.7.2.1 Emergency Services (during office hours).

7.7.2.2 Pulp treatment.

7.7.2.3 Routine fillings (amalgam and composite resin).

7.7.2.4 Simple extractions.

7.7.2.5 Complicated extractions.

7.7.2.6 Extraction of impacted teeth.

7.7.2.7 Periodontal prophylaxis (cleaning and polishing once every six months).

7.7.2.8 Periodontal treatment.

7.7.2.9 Pulpotomy and root canals (endodontic surgery and care).

7.7.2.10 Conscious sedation and nitrous oxide for Covered Persons under the age of 13.

7.7.3 Major Dental Services and Replacement Services.

7.7.3.1 Fixed prosthetics.

7.7.3.1.1 Crowns and bridges.

7.7.3.1.2 Gold inlays and onlays.

7.7.3.1.3 Repairs of crowns and bridges.

7.7.3.1.4 Replacement of crown or bridge (limited to once every five years)

7.7.3.2 Removable prosthetics.

7.7.3.2.1 Full and partial dentures. Replacements limited to once every five years.

7.7.3.2.2 Denture repair and relines.

7.7.3.3 General anesthesia, but only if medically or dentally necessary.

§7.8 Claims and Payment for Services. The procedures, requirements and conditions applicable to the processing and payment of claims for Medical Benefits contained in Article 6 shall apply to claims for Dental Services under this Agreement, except the Deductible amount does not apply to the Dental Benefits.

§7.9 Reasonableness and necessity of Services and charges.

7.9.1 Company shall not be required to pay any claim unless and until Company has determined that the Covered Person received Covered Services and that the charges for the Dental Services are reasonable. No payment shall be made for: (i) Dental Services not actually rendered; or (ii) Dental Services which are not Covered Services. No payment shall be made for any portion of a charge determined by Company to be unnecessary, unreasonable or excessive. In the case of a Participating Provider, when a Covered Person receives Covered Services, Company guarantees the Covered Person shall not be responsible for payment of any charges in excess of the Eligible Charges

7.9.2 Preliminary determination that any Dental Service or charge is unnecessary or unreasonable or otherwise not payable shall, at the Dentist's or Covered Person's request, be reviewed through Company's grievance procedure. The determination made through the grievance procedure shall be conclusive upon all parties in interest, subject, however to the parties' right to arbitration.

§7.10 Prior Authorization of Services. Prior Authorization by Company for Dental Services shall be required when any Treatment Plan and/or treatments exceed Five Hundred Dollars (\$500).

§7.11 General Provisions.

7.11.1 Dental Exclusions. No benefits will be paid for:

7.11.1.1 Work in progress on the effective date of coverage. Work in progress is defined as:

7.11.1.1.1 A prosthetic or other appliance, or modification of one, where an impression was made before the patient was covered.

7.11.1.1.2 A crown, bridge, or cast restoration for which the tooth was prepared before the patient was covered.

7.11.1.1.3 Root canal therapy, if the pulp chamber was opened before the patient was covered.

7.11.1.2 Services not specifically listed in the Agreement, Services not prescribed, performed or supervised by a Dentist, Services which are not medically or dentally necessary or customarily performed, Services that are not indicated because they have a limited or poor prognosis,

or Services for which there is a less expensive, professionally acceptable alternative.

- 7.11.1.3 Any Service unless required and rendered in accordance with accepted standards of dental practice.
- 7.11.1.4 A crown, cast restoration, denture or fixed bridge or addition of teeth to one, if work involves a replacement or modification of a crown, cast restoration, denture or bridge installed less than five years ago or one that replaces a tooth that was missing before the date of the Covered Person became eligible for Services under the plan (including previously extracted missing teeth).
- 7.11.1.5 Replacement of existing dentures, crowns or fixed bridgework if the existing dentures, crowns or fixed bridgework can be made serviceable
- 7.11.1.6 Precision attachments, Interlocking device, one component of which is fixed to an abutment or abutments the other is integrated into a fixed or removable prosthesis in order to stabilize and/or retain it; or stress breakers, part of a tooth borne and/or tissue-borne prosthesis designed to relieve the abutment teeth and their supporting tissues from harmful stresses.
- 7.11.1.7 Replacement of any lost or stolen appliance, or replacement of any appliance damaged while not in the mouth.
- 7.11.1.8 Any Service for which the Covered Person received benefits under any other coverage offered by the Company.
- 7.11.1.9 Spare or duplicate prosthetic devices.
- 7.11.1.10 Services included, related to, or required for:
 - 7.11.1.10.1 Implants;
 - 7.11.1.10.2 Cosmetic purposes;
 - 7.11.1.10.3 Services or appliances to change the vertical dimension or to restore or maintain the occlusion, including but not limited to, equilibrium, full mouth rehabilitation and restoration for malalignment of teeth;
 - 7.11.1.10.4 Temporomandibular joint (TMJ) or craniomandibular disorders, myofunctional therapy or the correction of harmful habits;
 - 7.11.1.10.5 Experimental procedures; and
 - 7.11.1.10.6 Intentionally self inflicted injury unless resulting from a medical condition (including physical or mental conditions) or from domestic violence.
- 7.11.1.11 Any over the counter drugs or medicine.

- 7.11.1.12 Fluoride varnish.
- 7.11.1.13 Charges for finance charges, broken appointments, completion of insurance forms or reports, providing records, oral hygiene instruction, pit and fissure sealants and dietary instruction, or lack of cooperation on the part of the patient.
- 7.11.1.14 Charges in excess of the amount allowed by the Plan for a Covered Service.
- 7.11.1.15 Any treatment, material, or supplies which are for orthodontic treatment, including extractions for orthodontics.
- 7.11.1.16 Services for which no charge would have been made had the Agreement not been in effect.
- 7.11.1.17 All treatments not specifically stated as being covered.
- 7.11.1.18 Surgical grafting procedures.
- 7.11.1.19 General anesthetic, conscious sedation, and other forms of relative analgesia, except as otherwise specifically provided herein.
- 7.11.1.20 Services paid for by Workers' Compensation.
- 7.11.1.21 Charges incurred while confined as an inpatient in a Hospital unless such charges would have been covered had treatment been rendered in a dental office.
- 7.11.1.22 Treatment and/or removal of oral tumors.
- 7.11.1.23 All surgical procedures except for surgical extractions of teeth and periodontal surgeries Performed by a Dentist. Surgical procedure is defined as the surgical and adjunctive treatment of diseases, injuries, and deformities of the oral and maxillofacial region.
- 7.11.1.24 Panoramic x-ray if provided less than three (3) years from the Covered Person's last full mouth x-rays; and full mouth x-rays if provided less than three (3) years from the Covered Person's last panoramic x-ray.

7.11.2 Issuance of this Agreement. This Article 7 shall take effect, and coverage for the Subscriber and Dependents initially listed on the Enrollment form shall commence as of the Subscriber's Effective Date if the Enrollment form is accepted by Company.

7.11.3 DENTAL COVERAGE SPECIAL CONDITIONS OF ENROLLMENT. EMPLOYEES MAY ELECT TO ENROLL IN THE MEDICAL PLAN ONLY BENEFIT LEVEL OR IN THE MEDICAL AND DENTAL PLAN BENEFIT LEVEL. MEMBERS ENROLLED IN THE MEDICAL PLAN ONLY BENEFIT LEVEL MAY ELECT TO ENROLL IN THE MEDICAL AND DENTAL PLAN DURING ANY OPEN ENROLLMENT PERIOD. ANY COVERED PERSON SELECTING THE MEDICAL AND DENTAL PLAN BENEFIT LEVEL SHALL ENROLL IN THE SAME CLASS FOR THE MEDICAL PLAN AND THE DENTAL PLAN.

ARTICLE 8

Rates

GOVGUAM HSA 2000

Rates for retired and active Covered Persons shall be effective from October 1, 2017 through September 30, 2018.

§8.1 Monthly rates:

	Medical	Dental
Actives		
Class I	\$107.99	\$32.09
Class II	\$223.17	\$74.51
Class III	\$188.22	\$60.04
Class IV	\$310.59	\$100.40
Retirees		
Class I	\$323.96	\$32.09
Class II	\$669.52	\$74.51
Class III	\$564.62	\$60.04
Class IV	\$931.78	\$100.40

§8.2 Bi-weekly rates (Actives):

	Medical	Dental
Class I	\$49.84	\$14.81
Class II	\$103.00	\$34.39
Class III	\$86.87	\$27.71
Class IV	\$143.35	\$46.34

§8.3 Semi-monthly rates (Retirees):

	Medical	Dental
Class I	\$161.98	\$16.04
Class II	\$334.76	\$37.26
Class III	\$282.31	\$30.02
Class IV	\$465.89	\$50.20

EXHIBIT A
Medical Schedule of Benefits

GOVGUAM HSA 2000

SCHEDULE OF BENEFITS

Your Benefits: What TakeCare covers	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Deductible Per Individual Member (Class 1)	\$2,000	\$4,000
Deductible Per Family (Class 2, 3 & 4) If an individual member of a family meets \$2,600 in covered expenses, the plan begins to pay for covered services for that individual	\$4,000	\$12,000
Coverage Maximums Individual member annual maximum	Unlimited	
Out of Pocket Maximums (including accumulated deductible, copayment, and co-insurance) Per Individual member per policy year Per Family per policy year	\$4,000 \$12,000	No Maximum No Maximum
Any Services in the Philippines, Hawaii & the U.S. Mainland, Japan, Taiwan and Foreign Participating Providers (Prior Authorization Required)	Requires a Referral from your Doctor and approval in advance from TakeCare	
Deductible and Co-Pay do not apply to these Benefits when you go to a Participating Provider	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS After deductible is met
Preventive Services (Out Patient Only) In accordance with the guidelines established by the U.S. Preventive Services Task Force (USPSTF) Grades A and B recommendations. <ul style="list-style-type: none"> Annual Physical Exam <ul style="list-style-type: none"> Members may choose to receive age appropriate annual physical in the Philippines with no dollar limit Breast Pumps (In accordance to Women's Preventive Health guidelines) Includes preventive lab tests 	Plan Pays 100%	Not Covered
Immunizations/Vaccinations In accordance with the guidelines established by the Advisory Committee on Immunization Practices of the CDC	Plan Pays 100%	Not Covered
Pre-Natal Care Including Routine Labs and First Ultrasound	Plan Pays 100%	Not covered
Well-Child Care <ul style="list-style-type: none"> Infancy (newborn to nine months) up to 7 visits per plan year Early childhood (one to four years old) up to 7 visits per plan year Middle Childhood/Adolescence (five to seventeen years old) up to one visit per plan year <ul style="list-style-type: none"> In accordance with the Bright Futures/American Academy of Pediatrics recommendations for Preventive Pediatric Health Care 	Plan Pays 100%	Not Covered
Well-Woman Care (In accordance with the guidelines supported by the Health Resource and Service Administration (HRSA)) <ul style="list-style-type: none"> Contraceptive including Sterilization and Tubal Ligation if prescribed. 	Plan Pays 100%	Not Covered
Deductible must be met for the following services	PARTICIPATING PROVIDERS After deductible is met	NON-PARTICIPATING PROVIDERS After deductible is met
Outpatient Laboratory		
1. Routine Laboratory	Plan pays 100%	Plan Pays 50% of Eligible Charges, Member pays 50%
2. Specialty Laboratory	\$20 Member Co-Payment	Plan Pays 50% of Eligible Charges, Member pays 50%

EXHIBIT A
Medical Schedule of Benefits
(Continuation)

Deductible must be met for the following services	PARTICIPATING PROVIDERS After deductible is met	NON-PARTICIPATING PROVIDERS After deductible is met
Acupuncture (Limited to 30 visits per member per benefit year)	Plan Pays 80% Member Pays 20%	Not Covered
AIDS Treatment (Prior Authorization Required) Exclusive of Experimental Drugs	Plan Pays 80% Member Pays 20%	Not Covered
Airfare Benefit to Preferred Providers only TakeCare provides emergency hospital to hospital transportation coverage (Prior Authorization Required)	Plan Pays 100%	Not Covered
Allergy Testing/Treatment \$1,000 per member per plan year	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Ambulatory Surgi-center Care (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Annual Eye Exam (once per member per plan year)	\$5 Member Co-Payment at FHP Clinic, \$10 Member Co-Payment at Preferred Provider, \$20 Member Co-Payment at Non-Preferred Provider Covered in Guam only	Not Covered
Blood & Blood Derivatives (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Breast Reconstructive Surgery (Prior Authorization Required) (In accordance with 1998 W.H.C.R.A)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Cardiac Surgery (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Cataract Surgery (Prior Authorization Required) Includes lens implants, Outpatient only	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Chemical Dependency	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Chemotherapy Benefit (Prior Authorization Required)	Plan Pays 80% Member pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Chiropractic Care (Limited to 30 visits per member per benefit year)	Plan Pays 80% Member Pays 20%	Not Covered
Congenital Anomaly Disease Coverage (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Not Covered
Diagnostic Testing MRI, CT Scan, Sleep Apnea (testing and other diagnostic procedure) (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Durable Medical Equipment (DME) The lesser amount between Purchase or Rental of crutches, walkers, wheelchairs, hospital beds, suction machines, nebulizer machine or oxygen, CPAP (excluding disposable supplies), oxygen and accessories when prescribed by a Physician (Prior Authorization Required)	Plan Pays 80% Member Pays 20% of the total rental cost or purchase	Not Covered
Elective Surgery (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Emergency Care (For on and off island emergencies, Plan must be contacted and advised within 48 hours) 1 On/Off Island emergency facility, physician services, laboratory, x-rays 2. Ambulance Services (Ground Transportation only)	Plan Pays 80% Member Pays 20%	Plan Pays 80% Member Pays 20%
End Stage Renal Disease / Hemodialysis (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Hearing Aids Maximum \$500 per member per plan year	Plan Pays 80% Member Pays 20%	Not Covered

EXHIBIT A
Medical Schedule of Benefits
(Continuation)

Deductible must be met for the following services	PARTICIPATING PROVIDERS After deductible is met	NON-PARTICIPATING PROVIDERS After deductible is met
Hospitalization & Inpatient Benefits (Prior Authorization Required) 1. Room & Board for a semi-private room, intensive care, coronary care and surgery 2. All other inpatient hospital services including laboratory, x-ray, operating room, anesthesia and medication 3. Physician's hospital services 4. Mental Health Care services	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Implants (Prior Authorization Required) Limited to cardiac pacemakers, heart valves, stents, Intraocular lenses, orthopedic internal prosthetic devices; (Limitations apply, please refer to contract and certificate of insurance)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Inhalation Therapy	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Maternity Care Labor and Delivery	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Outpatient Executive Check-up Services are covered at Participating Providers in the Philippines up to the cost but not exceeding Php13,250 per member per plan year. Benefit is not convertible to cash if unused during a plan year and cannot be applied towards any other services.	Plan Pays Up to Php 13,250 Member Pays All Charges Above Plan Payment	Not Covered
Outpatient Mental Health Care	\$5 Member Co-Payment at FHP Clinic, \$10 Member Co-Payment at Preferred Provider, \$20 Member Co-Payment at Non-Preferred Provider	Plan Pays 50% of Eligible Charges, Member pays 50%
Nuclear Medicine (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Occupational Therapy (Limited to 20 visits per member per benefit year) (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Not Covered
Organ Transplant – coverage based on Medicare including but not limited to the following organs. Includes coverage for donor expenses. 1. Heart 2. Lung 3. Liver 4. Kidney 5. Pancreas 6. Intestine 7. Bone Marrow 8. Cornea (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Orthopedic Conditions (Prior Authorization Required) Internal and External Prosthesis such as but not limited to artificial joints, limbs and spinals segments	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Outpatient Physician Care & Services		
1. Primary Care Visits	\$5 Member Co-Payment at FHP Clinic, \$10 Member Co-Payment at Preferred Provider, \$20 Member Co-Payment at Non-Preferred Provider	Plan Pays 50% of Eligible Charges, Member pays 50%
2. Specialist Care Visits	\$40 Member Co-Payment	Plan Pays 50% of Eligible Charges, Member pays 50%
3. Voluntary Second Surgical Opinion	\$40 Member Co-Payment	Plan Pays 50% of Eligible Charges, Member pays 50%

EXHIBIT A
Medical Schedule of Benefits
(Continuation)

Deductible must be met for the following services	PARTICIPATING PROVIDERS After deductible is met	NON-PARTICIPATING PROVIDERS After deductible is met
4. Home Health Care Visit	Plan Pays 100%	Plan Pays 50% of Eligible Charges, Member pays 50%
5. Hospice Care in Guam only, maximum 180 days at a maximum of \$150 per day (Prior Authorization Required)	\$40 Member Co-Payment	Not Covered
6. X-ray Services	\$10 Member Co-payment at FHP Clinic \$20 Member Co-payment outside FHP	Plan Pays 50% of Eligible Charges, Member pays 50%
7. Injections (Does not include those on the Specialty Drugs Lists and Orthopedic injections)	\$5 Member Co-Payment at FHP Clinic, \$10 Member Co-Payment at Preferred Provider, \$20 Member Co-Payment at Non-Preferred Provider	Plan Pays 50% of Eligible Charges, Member pays 50%
Optical Benefit Coverage for pair of contact lenses or eyeglasses lens/frames – maximum of \$150 per member per benefit year	Member Pays All Charges above \$150 per benefit year	All Charges
Physical Therapy (Prior Authorization Required)	Plan Pays 80% for the first 20 visits and 50% thereafter	Plan Pays 50% of Eligible Charges, Member pays 50%
Prescription Drugs		
1. Formulary generic drugs per prescription unit	\$10 Member Co-Payment at FHP Pharmacy, \$15 Member Co-Payment outside FHP Pharmacy (30 day supply)	Plan pays 50% of Average Wholesale Price
2. Formulary brand name drugs per prescription unit	\$30 Member Co-Payment (30 day supply)	
3. Formulary generic and brand mail order	\$0 Member Co-Payment	
4. Non-Formulary (Medically Necessary Only and Prior Authorization Required)	\$30 Member Co-Payment (30 day supply)	
Radiation Therapy (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Robotic Surgery/Robotic Suite (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 70% of Eligible Charges, Member pays 30%
Skilled Nursing Facility Maximum 60 days per member per plan year (Prior Authorization Required)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Specialty Drugs (Medically Necessary Only and Prior Authorization Required)	\$60 Member Co-payment (30 day supply)	Not Covered
Sterilization Procedures (Prior Authorization Required) 1. Vasectomy (Outpatient Only)	Plan Pays 80% Member Pays 20%	Plan Pays 50% of Eligible Charges, Member pays 50%
Urgent Care		
1. Within the Service Area (Available at FHP Health Center Only)	\$10 Member Co-payment	Not Covered
2. Outside the Service Area	Plan Pays 80% Member pays 20%	Plan Pays 80% of Eligible Charges, Member pays 20%

EXHIBIT A
Medical Schedule of Benefits
(Continuation)

Additional Benefits: What TakeCare covers

Wellness & Fitness Benefit

1. Wellness Benefit at TakeCare Wellness Center	Plan Pays 100%	Not Covered
2. TakeCare's Wellness and Disease Management Programs and Incentives	Plan Pays 100%	
3. Gym Benefit For list of gym partners, please contact TakeCare's Customer Service Department. Be advised that several gyms have maximum enrollment caps and is on a first come first serve basis.	Plan Pays 100% for Gym Access Per Member Per Plan Year	Not Covered

Participating Provider Benefit in the Philippines (Prior Authorization is Required)

Applicable copayment and co-insurance are waived for eligible and covered in-patient and out-patient services after meeting the deductible	Plan Pays 100%	Not Covered
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EXHIBIT B

Dental Schedule of Benefits

Your Benefits: What TakeCare covers	PARTICIPATING PROVIDERS Plan Pays	NON-PARTICIPATING PROVIDERS Plan Pays
Diagnostic & Preventive Care		
1. Caries Susceptibility Test 2. Exams (Once every 6 months) 3. Fluoride Treatment (Annually for children age 19 & under) 4. Prophylaxis (Cleaning of teeth once every 6 months) 5. Sealants (For permanent molars and children age 15 & under) 6. Space maintainers (For children age 15 & under) includes adjustments within 6 months of installation 7. Study Models 8. Treatment Plan 9. X-rays (Bite Wing Maximum of 4 per Plan Year) 10. X-rays (Full mouth, once every 3 years)	100% of Eligible Expenses	70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)
Basic & Restorative Care		
General Services 1. Emergency Care (During office hours) 2. Pulp Treatment 3. Routine Fillings (Silver & composite resin) Oral Surgery 1. Simple Extractions 2. Complicated Extractions 3. Extraction of impacted teeth Periodontal Care 1. Periodontal Prophylaxis (Cleaning once every 6 months) 2. Periodontal Treatment Conscious Sedation and Nitrous Oxide for children under the age of 13.	80% of Eligible Expenses	70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)
Pulpotomy & Root Canals/Endodontic Surgery Care	80% of Eligible Expenses	70% of Eligible Expenses (Covered Person pays excess above Eligible Expenses)
Major & Replacement Care		
Fixed Prosthetics 1. Crowns 2. Gold Inlays & Onlays 3. Bridges (Fixed) 4. Replacement of Crown Restoration (Once every 5 years) Removable Prosthetics 1. Full Dentures (Once every 5 years) 2. Partial Dentures (Once every 5 years) 3. Each anesthesia, but only if medically or dentally necessary 4. Relines 5. Denture Repair Periodontics Treatment of soft tissue and bones supporting the teeth	50% of Eligible Expenses	35% of Eligible Expenses
Deductible	None	None
Registration Fee Per Visit To Dentists	None	None
Coverage Maximums Per Member per Plan Year	\$1,000	

EXHIBIT C

Wellness and Disease Management Benefit

As a healthcare organization, TakeCare is committed to provide Government of Guam (“GovGuam”) members with quality health care services. It is our mission to help improve our member’s health and well-being, provide tools that will help our members achieve their health goals, and support our member’s abilities for self-care. TakeCare offers in-house exclusive to members Wellness programs designed to help manage chronic diseases:

- **Wellness Workshop**

TakeCare has developed the “Wellness Workshop”, facilitated by our full-internal FHP medicine provider, Dr. Edwin Supit. The program addresses prevention and management strategies for chronic diseases such as diabetes, high blood pressure, high cholesterol levels and obesity. The program includes an eight session class intended to improve the individuals health through plant-based nutrition. The program also helps members gain knowledge and understanding of their disease and develop skills in managing their condition. The program emphasis is on improving health with vital signs monitoring for blood pressure, random glucose, and weight and body mass index (“BMI”) measures as conducted during each class session. Initial comprehensive lab test are provided before the start of the program and a final lab test to measure improvement is also provided before the end of the program.

The workshop discusses of the following topics:

- Understanding the metabolic syndrome, insulin resistance & reversing diabetes.
- Overcoming cellular stress, mitochondrial over-drive & burnout, adrenal fatigue.
- Understanding stimulant over-drive, optimizing melatonin cycle for natural healing.
- Understanding endothelial injury, hypertension & atherosclerosis.
- Look and feel better, keep cells younger with high-antioxidant foods.
- Improving cellular detoxification, decreasing pain & addressing inflammation, improving immune function, improving cellular signaling, cell-membrane fluidity, overcoming obesity and weight management.

The program provides support to TakeCare members through services offered by trained nurse educators and nutritionists. Telephonic consultations and on-on-one appointments are offered free of charge to members to gain a better understanding of their disease process and develop skills that will empower them improve their self-care.

- **Cardiac Risk Management Program**

TakeCare provides Cardiac Risk Management (“CRM”) Program for exclusive for TakeCare members designed primarily to target those with high blood pressure and high cholesterol and aims to prevent the onset and progression of heart and vascular disease through patient education. The purpose of the CRM Program is to reduce cardiac risk such as stroke and heart attack, improve the quality of life among participants by living a heart healthy lifestyle, and promote compliance with

management and medication adherence. The program includes initial lab test for lipid profile and comprehensive metabolic profile (CMP) to test liver and kidney functions. A follow-up laboratory testing after six (6) months of participation in the program and a telephonic monitoring and follow-up with Registered Nurse Case Manager is provided. Blood pressure screening, weight and BMI check, are conducted to identify health risk are conducted during the two (2) hour class.

Class session includes the following topics:

1. Risk factors, Causes and complications of high blood pressure and high cholesterol
2. Progression of disease
3. Know your numbers:
 - i. Stages of Hypertension
 - ii. Cholesterol levels in the blood
 - iii. Goals
4. Lifestyle changes to prevent development of hypertension and hypercholesterolemia
5. Nutrition Topics:
 - i. DASH diet/Low Fat diet
 - ii. Sodium/Potassium balance
 - iii. Cholesterol and the different types and sources of fats
 - iv. Understand food label and nutrition facts
 - v. Portion control
6. Stress, Exercise and Physical Activity

The program is directed by a fulltime nurse case manager who will assist patients with history of non-compliance in medication, exercise regime, diet and doctor's follow up appointment. Support staff includes a wellness manager, a fitness expert and a nutritionist. Social workers and case managers will also help address the socioeconomic issues affecting patient's health care.

• **Diabetes Management Program**

TakeCare's Diabetes Management Class is intended for members who are newly diagnosed with diabetes or members with diabetes who have not had a diabetic teaching in the past. It teaches members about the disease process, how to achieve or maintain a healthy blood sugar range and strategies on how to prevent complications.

It emphasizes medication compliance, glucose monitoring, proper diet, regular physical activity and timely medical evaluation. This program is designed to assist in making diabetic patient self-manage their condition and to encourage them to make changes that will improve their over-all health and well-being. The program will consist of the following interventions:

Initial laboratory testing for lipid profile, HbA1c and comprehensive metabolic profile to check kidney and liver functions, and a follow-up laboratory test after six (6) months of participating in the program. Initial random glucose screening, foot exam, blood pressure screening, weight and BMI check, one two (2) hour session with free educational handouts, telephonic monitoring and follow-up with Registered Nurse Case Manager are also part of the program.

One 2-hour session that discusses the following topics:

- Understanding Diabetes and the disease process
- Managing blood sugar: Hypoglycemia/Hyperglycemia and sick days
- Diabetic introduction video
- Preventing complications
- Knowing blood glucose numbers and determining healthy ranges on other diagnostic lab work *Includes blood glucose monitor teaching.*
- Therapeutic lifestyle changes and physical activity
- Nutrition basics: Diabetic meal planning, food label reading, calorie and carbohydrate counting and healthy food preparation techniques

- **TakeCare's Group Fitness Program**

TakeCare has a well-developed fitness program available to all TakeCare GovGuam members. TakeCare's Group Fitness Program is an organized variety of classes available to the eligible GovGuam plan members. The program consists of various fitness activities in both indoor and outdoor settings that includes low to high impact, aerobic and muscle building exercises that are designed to meet individuals fitness level while keeping them engaged in their workout and improve their fitness abilities. Through TakeCare's partnership with different fitness instructors, gym partners and other health organizations, members are able to choose from a variety of exercise activities that will appeal more to their needs, interests and lifestyle. Exhibit 17 is a sample of our monthly fitness calendar.

The goal of the program is to increase the member's participation in fitness and exercise activities that provide opportunities to maintain a healthy and active lifestyle. The variety of fitness activities provided in the group fitness classes support and supplement all of TakeCare's education and disease management program.

In addition, TakeCare has established partnerships with various fitness facilities on island that provide access to members to take advantage of their fitness program offerings.

- **Nicotine Cessation Program**

In conjunction with American Cancer Society's Freshstart Program, TakeCare administers and offers a tobacco and nicotine cessation program to all TakeCare Members.

The program includes a one hour session for a total of four weeks designed to educate, empower, and assist individuals who desire to quit smoking.

The sessions include topics on understanding the basic concepts of addiction, effects of smoking, benefits and methods of quitting smoking and managing the first few days of quitting, including instructions on medications, support systems, and follow-up. Following the format of the Freshstart Program, participants are encouraged to identify a quit date followed by individual and group counseling sessions. Participants who failed to quit on the identified quit dates are encouraged to set another quit date and continuous telephonic counseling is done to ensure adequate follow-up. Prescription medication are available free of charge for members needing assistance to wean off nicotine addiction.

(A quit attempt is defined as at least one counseling session and a corresponding smoking cessation medication reimbursed within a 90-day period.) TakeCare's Nicotine Cessation Program is facilitated by certified American Cancer Society facilitator.

- **Well Mommy-Well Baby Program**

The Well Mommy- Well Baby Program is designed to provide educational support to pregnant women and their families, assist pregnant mothers to have a normal and healthy pregnancy. A Registered nurse will provide telephonic consult to identify and assess pregnancy risks and facilitate referrals to specialty case management services. In partnership with Reinsurance Group of America ("RGA"), The Well Mommy-Well Baby program provides access to trained perinatal case managers who can provide personalized (one-on-one) counseling and coaching to pregnant mothers. A comprehensive assessment is done and for any identified risks, members are channeled to the right specialty for early intervention. Members are provided free educational materials and handouts as well as free access to Lamaze classes, Prenatal Yoga and other Prenatal Nutrition and Education classes. The program applies to eligible TakeCare members in their second (2nd) trimester. Automatic enrollment is applied to all FHP paneled patients. Patients under network providers can send referral for enrollment to the program by e-mail at Wellness@takecareasia.com or fax at 647-3541 ATTN: Wellness. Enrollment to the program is free and self-referral from eligible members is also accepted.

- **Children's Health Improvement Program ("CHIP")**

TakeCare's Children's Health Improvement Program (CHIP) is a family-oriented health education program geared to those who are over the 85th percentile with or without health risks aging seven to fourteen (7 to 14) years old along with their parents/guardian. Although this program is intended for overweight and obese children, we welcome all TakeCare Kids within the age range (7 to 14 years) to participate as preventative measures for childhood obesity.

The goal of the program is to provide a family-oriented nutrition education and physical fitness activities for children and adolescents. The program encourages the participants to make healthy food choices and lifestyle changes; each class session includes 1 hour fitness class and 1 hour nutrition education and food demonstration.

CHIP offers the follow services:

- Six Saturdays with group nutrition and fitness classes from certified instructors
- Provides telephone counseling support to assist members with lifestyle issues
- Provides a class room setting nutrition education
- Guidance and monitoring from FHP Healthcare provider, if needed
- Free educational materials for parents and children on nutrition, fitness and lifestyle

- **Teen Talk Program**

According to the Youth Risk Behavior Surveillance (2013), adolescences [ages 12 to 17] are vulnerable at engaging in health-risk behaviors. These health-risk behaviors can contribute to several public health and social consequences as well as morbidity and mortality rates.

The top leading causes of morbidity and mortality rates are: 1) Behaviors leading to unintentional injuries and violence; 2) Substance abuse (nicotine, alcohol and drugs); 3) Sexual behaviors that contribute to unintended pregnancy and transmission of STDs and HIV; 4) Unhealthy dietary behaviors; and 5) Physical inactivity (CDC, 2013).

The TakeCare Wellness Teen Talk Program's purpose is to provide health education workshops for adolescence ages twelve (12) to seventeen (17) years of age and aims to minimize or prevent public health and social consequences and to develop and encourage healthy behaviors.

The Teen Talk Program offers the following services:

a) Group educational sessions, tools and resources relating to but not limited to:

- Substance Abuse (nicotine, drug and alcohol use) – this session helps educate adolescents on the harmful effects of nicotine, drug and alcohol usage; prevents or reduce the health and social consequences of nicotine, drug and alcohol usage; and encourage living a substance abuse free lifestyle.
- Sexual Risk Behaviors and Unplanned Teenage Pregnancy – this session helps adolescents embrace lifelong attitude and behaviors that support their health and welling being such as reducing their risk of contracting sexually transmitted infections (STIs), Human Immunodeficiency Virus (HIV), and unintended pregnancy.
- Violence Issues – this session offers adolescents to identity types of violence: such as bullying, sexual harassment/assault, dating violence, etc. as well as various prevention violence strategies before they occur.
- Suicide Prevention – this session informs adolescents how to recognize the warning signs of suicide; to develop an alertness and provide effective communication with at-risk individuals; how to inform the at risk individuals to seek professional assistance; and to create a support system and prevention strategies.
- Nutrition and Physical Activity – this session provides participants with ways to choose healthy food that promotes optimal growth and development and participation in regular physical activities that helps reduce the risk of developing non-communicable diseases such as diabetes, cardiovascular disease, cancer, pulmonary diseases, etc.

b) Provide various activities that foster self and social development:

- i) Team building activities.
 - ii) Improving communication amongst friends and family.
 - iii) Big brother or sister bonding during adolescence.
- **Worksite Wellness sessions**

Take Care's Wellness team believes that through health education, wellness activities and opportunities for self-improvement, we can enhance the quality of life and decrease the risk of chronic diseases. In an effort to integrate health promotional activities in your workplace, Take Care

Wellness offers lunch and learning sessions at the Company's requested time and location. Worksite Wellness sessions are informative sessions lasting about one to two hours that focus on a variety of health topics. In addition to free access to our Health Education, Disease Management and Fitness classes at our facility, we can also bring these classes to the worksite. We can also customize health and wellness topics specific to the employer's needs and interests. We want to ensure that time spent during these sessions are fully optimized.

- **Nutrition Counseling**

TakeCare's trained nutritionists and health educators work closely with our members to provide one-on-one, personalized counseling on the health and nutrition. Members are counseled on various nutrition related issues including diabetes meal planning, DASH diet, vegetarian/vegan diets, and other modified diets. Members with chronic conditions are also counseled on medical nutrition therapy for nutrition related diseases and disorders.

- **Nurse Case Management**

TakeCare offers Nurse Case Management to members needing assistance on managing chronic diseases. Registered Nurse Care manager helps designs individualized preventive and management specific to their condition. The Nurse Case Manager works hand in hand with the patient's primary care provider to ensure coordination of care.

- **Health Risk Assessment**

TakeCare's Health Risk Assessment ("HRA") is administered through a web portal that can be found in TakeCare's website. The HRA is an on-line self –assessment tool that can be completed as a part of an annual wellness visit with a health care professional. During the visit, the HRA information and other biometrics available are utilized by the practitioner in a thought process intended to develop a prevention plan to improve health status and delay the onset of disease. TakeCare's HRA is offered through RedBrick Health. The HRA is an interactive online health questionnaire designed to get people to be meaningfully engaged and help members achieve their health goals.

Covered adults members, age 18 and older, can earn the \$25 HRA Wellness Incentive by providing evidence of completing the TakeCare HRA during the current calendar year. Completing an HRA helps members make an important first step toward improving their awareness of lifestyle behaviors and their effect on overall health risks. On completion of the HRA, a Personal Health Report is generated automatically when the Assessment is completed. This information can be shared with the medical provider or other health care professional during any routine annual/wellness visit.

- **We "CARE" Program – Connecting members and providing Assistance, Resources and Encouragement**

The We "CARE" program is designed to support members health and mental well-being by connecting them to appropriate services, providing educational assistance, resource tools and

encourage overall wellness. The purpose is to bridge the gap with members needing referral services to community partners.

EXHIBIT D

Immunization Schedule


Recommended Adult Immunization Schedule—United States - 2015


Note: These recommendations must be read with the footnotes that follow containing number of doses, intervals between doses, and other important information.

Figure 1. Recommended adult immunization schedule, by vaccine and age group¹

VACCINE ▼	AGE GROUP ►	19-21 years	22-26 years	27-49 years	50-59 years	60-64 years	≥ 65 years
Influenza ^{2,3}		1 dose annually					
Tetanus, diphtheria, pertussis (Td/Tdap) ^{3,4}		Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs					
Varicella ^{4,5}		2 doses					
Human papillomavirus (HPV) Female ^{6,7}		3 doses					
Human papillomavirus (HPV) Male ^{8,9}		3 doses					
Zoster ⁴						1 dose	
Measles, mumps, rubella (MMR) ^{2,7}		1 or 2 doses					
Pneumococcal 13-valent conjugate (PCV13) ^{10,11}		1-time dose					
Pneumococcal polysaccharide (PPSV23) ⁹		1 or 2 doses					1 dose
Meningococcal ⁹		1 or more doses					
Hepatitis A ¹⁰		2 doses					
Hepatitis B ¹¹		3 doses					
Haemophilus influenzae type b (Hib) ¹²		1 or 3 doses					

¹Covered by the Vaccine Injury Compensation Program

 For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection; zoster vaccine recommended regardless of prior episode of zoster

 Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indication)

 No recommendation

Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at www.vaers.hhs.gov or by telephone, 800-822-7967.

Information on how to file a Vaccine Injury Compensation Program claim is available at www.hrsa.gov/vaccinecompensation or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005; telephone, 202-357-6400.

Additional information about the vaccines in this schedule, extent of available data, and contraindications for vaccination is also available at www.cdc.gov/vaccines or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 8:00 a.m. - 8:00 p.m. Eastern Time, Monday - Friday, excluding holidays.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), American College of Obstetricians and Gynecologists (ACOG) and American College of Nurse-Midwives (ACNM).

EXHIBIT D

Immunization Schedule (Continuation)

Figure 2. Vaccines that might be indicated for adults based on medical and other indications¹

VACCINE ▼	INDICATION ►	Pregnancy	Immuno-compromising conditions (excluding human immunodeficiency virus [HIV]) ^{4,7,10}	HIV infection CD4+ T lymphocyte count ^{4,7,11}	Men who have sex with men (MSM) ⁸	Kidney failure, end-stage renal disease, receipt of hemodialysis	Heart disease, chronic lung disease, chronic alcoholism	Asplenia (including elective splenectomy and persistent complement component deficiencies) ^{4,12}	Chronic liver disease	Diabetes	Healthcare personnel
Influenza ²			1 dose IIV annually	< 200 cells/μL	≥ 200 cells/μL	1 dose IIV or LAIV annually	1 dose IIV annually				1 dose IIV or LAIV annually
Tetanus, diphtheria, pertussis (Td/Tdap) ³		3 dose Tdap each pregnancy	Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs								
Varicella ⁴		Contraindicated					2 doses				
Human papillomavirus (HPV) Female ⁵			3 doses through age 26 yrs				3 doses through age 26 yrs				
Human papillomavirus (HPV) Male ⁵			3 doses through age 26 yrs				3 doses through age 21 yrs				
Zoster ⁶		Contraindicated					1 dose				
Measles, mumps, rubella (MMR) ⁷		Contraindicated					1 or 2 doses				
Pneumococcal 13-valent conjugate (PCV13) ⁸							1 dose				
Pneumococcal polysaccharide (PPSV23) ⁸							1 or 2 doses				
Meningococcal ⁹							1 or more doses				
Hepatitis A ¹⁰							2 doses				
Hepatitis B ¹¹							3 doses				
Haemophilus influenzae type b (Hib) ¹²			post-HSCT recipients only				1 or 3 doses				

¹Covered by the Vaccine Injury Compensation Program



For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection; zoster vaccine recommended regardless of prior episode of zoster



Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)



No recommendation



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

These schedules indicate the recommended age groups and medical indications for which administration of currently licensed vaccines is commonly recommended for adults ages 19 years and older, as of February 1, 2015. For all vaccines being recommended on the Adult Immunization Schedule, a vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. For detailed recommendations on all vaccines, including those used primarily for travelers or that are issued during the year, consult the manufacturers' package inserts and the complete statements from the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/hcp/acip-recs/index.html). Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

EXHIBIT D

Immunization Schedule (Continuation)

Figure 1. Recommended immunization schedule for persons aged 0 through 18 years – United States, 2015.

(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE (FIGURE 2)).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded.

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19–23 mos	2–3 yrs	4–6 yrs	7–10 yrs	11–12 yrs	13–15 yrs	16–18 yrs
Hepatitis B ¹ (HepB)	1 st dose	2 nd dose			3 rd dose											
Rotavirus ² (RV) RV1 (2-dose series); RV5 (3-dose series)		1 st dose	2 nd dose	See footnote 2												
Diphtheria, tetanus, & acellular pertussis ³ (DTaP; <7 yrs)		1 st dose	2 nd dose	3 rd dose				4 th dose				5 th dose				
Tetanus, diphtheria, & acellular pertussis ⁴ (Tdap; ≥7 yrs)														(Tdap)		
Haemophilus influenzae type b ⁵ (Hib)		1 st dose	2 nd dose	See footnote 5			3 rd or 4 th dose See footnote 5									
Pneumococcal conjugate ⁶ (PCV13)		1 st dose	2 nd dose	3 rd dose			4 th dose									
Pneumococcal polysaccharide ⁶ (PPSV23)																
Inactivated poliovirus ⁷ (IPV; <18 yrs)		1 st dose	2 nd dose	3 rd dose								4 th dose				
Influenza ⁸ (IV; LAN) 2 doses for some. See footnote 8							Annual vaccination (IV only) 1 or 2 doses				Annual vaccination (IAIV or IV) 1 or 2 doses			Annual vaccination (LAN or IV) 1 dose only		
Measles, mumps, rubella ⁹ (MMR)					See footnote 9		1 st dose					2 nd dose				
Varicella ¹⁰ (VAR)							1 st dose					2 nd dose				
Hepatitis A ¹¹ (HepA)							2-dose series. See footnote 11									
Human papillomavirus ¹² (HPV2: females only; HPV4: males and females)														(3-dose series)		
Meningococcal ¹³ (Hib-MenCY ≥ 6 weeks; MenACWY-D ≥ 9 mos; MenACWY-CRM ≥ 2 mos)														1 st dose		

 Range of recommended ages for all children	 Range of recommended ages for catch-up immunization	 Range of recommended ages for certain high-risk groups	 Range of recommended ages during which catch-up is encouraged and for certain high-risk groups	 Not routinely recommended
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This schedule includes recommendations in effect as of January 1, 2015. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at <http://www.cdc.gov/vaccines/hcp/acip-recs/index.html>. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (<http://www.vaers.hhs.gov>) or by telephone (800-822-7967). Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for vaccination, is available from CDC online (<http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm>) or by telephone (800-CDC-INFO [800-232-4636]).

This schedule is approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/acip/>), the American Academy of Pediatrics (<http://www.aap.org>), the American Academy of Family Physicians (<http://www.aafp.org>), and the American College of Obstetricians and Gynecologists (<http://www.acog.org>).

NOTE: The above recommendations must be read along with the footnotes of this schedule.

EXHIBIT D

Immunization Schedule (Continuation)

FIGURE 2. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind—United States, 2014.

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. Always use this table in conjunction with Figure 1 and the footnotes that follow.

Persons aged 4 months through 6 years					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to dose 2	Dose 2 to dose 3	Dose 3 to dose 4	Dose 4 to dose 5
Hepatitis B ¹	Birth	4 weeks	8 weeks and at least 16 weeks after first dose; minimum age for the final dose is 24 weeks		
Rotavirus ²	6 weeks	4 weeks	4 weeks ²		
Diphtheria, tetanus, & acellular pertussis ³	6 weeks	4 weeks	4 weeks	6 months	6 months ³
<i>Haemophilus influenzae</i> type b ⁴	6 weeks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose) if first dose administered at age 12 through 14 months No further doses needed if first dose administered at age 15 months or older	4 weeks ⁴ if current age is younger than 12 months and first dose administered at < 7 months old 8 weeks and age 12 months through 59 months (as final dose) ⁴ if current age is younger than 12 months and first dose administered between 7 through 11 months (regardless of Hib vaccine [PRP-T or PRP-OMP] used for first dose), OR if current age is 12 through 59 months and first dose administered at younger than age 12 months; OR first 2 doses were PRP-OMP and administered at younger than 12 months. No further doses needed if previous dose administered at age 15 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 through 59 months who received 3 (PRP-T) doses before age 12 months and started the primary series before age 7 months	
Pneumococcal ⁵	6 weeks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose for healthy children) if first dose administered at age 12 months or older No further doses needed for healthy children if first dose administered at age 24 months or older	4 weeks if current age is younger than 12 months 8 weeks (as final dose for healthy children) if current age is 12 months or older No further doses needed for healthy children if previous dose administered at age 24 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age	
Inactivated poliovirus ⁷	6 weeks	4 weeks ⁷	4 weeks ⁷	6 months ⁷ minimum age 4 years for final dose	
Meningococcal ¹³	6 weeks	8 weeks ¹³	See footnote 13	See footnote 13	
Measles, mumps, rubella ⁸	12 months	4 weeks			
Vaccine ⁹	12 months	3 months			
Hepatitis A ¹¹	12 months	6 months			
Persons aged 7 through 18 years					
Tetanus, diphtheria, tetanus, diphtheria, & acellular pertussis ³	7 years ⁴	4 weeks	4 weeks if first dose of DTaP/DT administered at younger than age 12 months 6 months if first dose of DTaP/DT administered at age 12 months or older and then no further doses needed for catch-up	6 months if first dose of DTaP/DT administered at younger than age 12 months	
Human papillomavirus ¹²	9 years	Routine dosing intervals are recommended ¹²			
Hepatitis A ¹¹	12 months	6 months			
Hepatitis B ¹	Birth	4 weeks	6 weeks (and at least 16 weeks after first dose)		
Inactivated poliovirus ⁷	6 weeks	4 weeks	4 weeks ⁷	6 months ⁷	
Meningococcal ¹³	6 weeks	8 weeks ¹³			
Measles, mumps, rubella ⁸	12 months	4 weeks			
Vaccine ⁹	12 months	3 months if person is younger than age 13 years 4 weeks if person is aged 13 years or older			

EXHIBIT E

TakeCare's Performance Guarantee

Metric		Performance Guarantee Amount
CLAIMS ADJUDICATION and ADMINISTRATION		
1.a	TakeCare guarantees a turnaround time for 99% of clean paper claims to be processed within 45 business days of receipt	\$5,000 annually
1.b	TakeCare guarantees a claim financial accuracy of 98% or higher	\$5,000 annually
1.c	TakeCare guarantees a claim payment accuracy of 98% or higher	\$15,000 annually
CUSTOMER and MEMBER SERVICES		
2.a	Average Speed of Answer TakeCare guarantees that the average speed of answer (ASA) for 100% of member service calls are within 30 seconds or less.	\$5,000 annually
2.b	On going ID cards issuance 99% of ID cards processed and mailed within 15 business days	\$10,000 annually
2.c	Member Satisfaction 85% or higher member satisfaction based on unit level	\$10,000 annually
2.d	Call Abandonment Rate The abandonment rate for calls will be less than or equal to 2%. The abandonment rate does not include calls terminated by members in less than 30 seconds or call handled within the Interactive Voice Response (IVR) system.	\$5,000 annually
2.e	First Call Resolution 90% of calls are resolved during the member's first call or contact with TakeCare.	\$5,000 annually
2.f	Processing of On going Eligibility Information 100% of eligibility information and processing are completed within 3 business days	\$10,000 annually
2.g	Participant Email Response Performance Responses are provided to 90% of members emails within 3 business days from receipt of member's emails.	\$5,000 annually
ACCOUNT MANAGEMENT		
3.a	Account Management Satisfaction Account management satisfaction should have an average score of 3 or higher out of 5	\$10,000 annually
3.b	Account Management Reporting Required reports needs to be provided within 15 business days.	\$10,000 annually
3.c	Account Management Issues Resolution Account management issues needs to be resolved within 1 business day.	\$10,000 annually

EXHIBIT F

Appeals Procedures

I. APPEAL

As a Covered Person you have the right to appeal an Adverse Benefit Determination. There are two methods of appeal: Internal and External. The Internal Appeal is to TakeCare itself; the External Appeal is to the federal Office of Personnel Management.

The Internal Appeal is the first step of the appeal process. During the Internal Appeal you may request additional information about the Adverse Benefit Determination made by TakeCare and may ask TakeCare to reconsider its determination. Adverse Benefit Determinations arising under Medical and Dental Health Plans are subject to the Internal Appeal Process.

The External Appeal is the second step of the appeal process. An External Appeal is filed after an Internal Appeal is exhausted and TakeCare has decided not to reconsider its determination. Adverse Benefit Determinations arising under Medical Health Plans only are subject to the External Appeal Process. Adverse Benefit Determinations arising under Dental Health Plans are not subject to the External Appeal Process.

Covered Persons appealing an Adverse Benefit Determination must follow the procedures set forth in these Appeal Procedures.

II. DEFINITIONS

For the purposes of these Appeal Procedures, the following definitions shall apply:

Adverse Benefit Determination. An *Adverse Benefit Determination* means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan (e.g., a rescission of coverage), and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Appeal. An *appeal* means a request by a Covered Person for review and reconsideration of an Adverse Benefit Determination. For the purposes of these Appeal Procedures, the terms "appeal" and "claim" may be used interchangeably.

Authorized Representative. An *Authorized Representative* means an individual authorized in writing by a Covered Person to represent the Covered Person under the Internal Appeal Process and/or External Appeal Process. Such representation includes the right to receive and review information and documents on behalf of the Covered Person, including a Covered Person's confidential information.

Claim. A *claim* means a Covered Person's assertion that a particular service, benefit or payment is covered under a plan. For the purposes of these Appeal Procedures, the terms "appeal" and "claim" may be used interchangeably.

Claimant. A *Claimant* means a Covered Person who makes a claim for benefits under the Internal Appeal Process or the External Appeal Process. For purposes of Appeals, references to a Covered Person or Claimant may also include a Claimant's Authorized Representative.

Concurrent Care Claim. A *Concurrent Care Claim* means a claim involving care that TakeCare has previously approved or an ongoing course of treatment to be given over a period of time or a number of treatments, and any reduction or termination by TakeCare of that care before the end of such period of time or number of treatments.

Concurrent Care Extension Claim. A *Concurrent Care Extension Claim* means a claim whereby a Covered Person has received approval from TakeCare for concurrent care and wishes to extend the course of treatment beyond the period of time or number of treatments previously approved by TakeCare.

Expedited External Appeal. An *Expedited External Appeal* means a request for resolution of an appeal outside the normal time frame for appeal when (1) the time frame for completing an Internal Appeal would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function; or (2) following receipt of an Internal Appeal Determination that denied benefits, the timeframe for conducting a standard external appeal would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function.

External Appeal. An *External Appeal* means a Covered Person's written request (unless it is an Expedited External Appeal) for an independent review and reconsideration of an Adverse Benefit Determination (including an Internal Appeal Determination) once the Internal Appeal Process has been exhausted and which is conducted pursuant to the External Appeal Process. Adverse Benefit Determinations arising under Medical Health Plans only are subject to the External Appeal Process. Adverse Benefit Determinations arising under Dental Health Plans are not subject to the External Appeal Process.

The only Adverse Benefit Determinations subject to External Appeal include claims that involve (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment); or (2) a Rescission of coverage, other than Rescissions based on a failure to pay premiums.

External Appeal Decision. An *External Appeal Decision* means a decision by an independent review organization at the conclusion of an External Appeal.

Internal Appeal. An *Internal Appeal* means a Covered Person's written request (unless it is an Urgent Care Claim) for review and reconsideration of an Adverse Benefit Determination in the first instance pursuant to the Internal Appeal Process. Adverse Benefit Determinations arising under Medical and Dental Health Plans are subject to the Internal Appeal Process.

Internal Appeal Determination. An *Internal Appeal Determination* means a determination by TakeCare at the conclusion of an Internal Appeal.

Non-urgent Care Claim. A *Non-urgent Care Claim* means any claim for a benefit which is not an Urgent Care Claim.

Notice of Denial of Internal Appeal. A *Notice of Denial of Internal Appeal* means notification to a Covered Person that their Internal Appeal of an Adverse Benefit Determination has been upheld by TakeCare at the completion of the Internal Appeal Process.

Pre-service Claim. A *Pre-service Claim* means any claim for a benefit for which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care, or a determination of no coverage under the plan.

Post-service Claim. A *Post-service Claim* means any claim for a benefit that is not a Pre-service Claim.

Rescission. A *Rescission* means termination of a Covered Person's coverage back to the initial date of coverage based on a Covered Person committing an act that constitutes fraud or intentionally misrepresenting a material fact prohibited by the terms of the plan.

Urgent Care Claim. An *Urgent Care Claim* means any claim for medical care or treatment that, if not quickly decided outside of standard time periods for making non-urgent care determinations, (1) could seriously jeopardize the life or health of the individual or the ability of the individual to regain maximum function; or (2) in the opinion of a physician with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

III. INTERNAL APPEAL PROCESS

A. PROCEDURES FOR INTERNAL APPEAL

1. When to Request an Internal Appeal.

a. **Time Limit.** You or your Authorized Representative may file an Internal Appeal within one hundred eighty (180) calendar days of receipt of an Adverse Benefit Determination. If you choose to have someone act on your behalf during the appeal, you must appoint an Authorized Representative in writing and complete TakeCare's Authorization to Release and Disclose Protected Health Information prior to TakeCare releasing any confidential or protected health information to your representative. During an Internal Appeal, you or your Authorized Representative may also be referred to as "Claimant."

b. **Urgent Care Claim.** If your appeal is an Urgent Care Claim or Concurrent Care Claim involving urgent care, your request may be filed immediately with the TakeCare Customer Service Department. In the event an appeal of an Urgent Care Claim needs to be made outside of normal business hours (including weekends and holidays), you may contact TakeCare's Health Plan Administrator at (671) 488-7107. TakeCare will appoint an individual at TakeCare to provide you with an Internal Appeal Determination (whether adverse or not), taking into account the medical exigencies, not later than seventy-two (72) hours after receipt of your appeal by TakeCare. The individual who decides your Urgent Care Claim will not be someone involved in the initial Adverse Benefit Determination. The Individual who decides your Urgent Care Claim will be a health professional with training relevant to the claim if the Adverse Benefit Determination is based in whole or in part on medical judgment, including whether a given treatment is experimental, investigational, or not medically necessary or appropriate. If you fail to provide TakeCare with sufficient information to determine whether, or to what extent, benefits may be covered or payable under TakeCare's Plan, TakeCare shall notify you not later than twenty-four (24) hours after receipt of the appeal, of the specific information required. You will be provided reasonable time, but not less than forty-eight (48) hours, to provide TakeCare with the information. Thereafter, TakeCare will notify you of its Internal Appeal Determination no later than forty-eight (48) hours after the earlier of TakeCare's receipt of the requested

information or the end of the time given to the Claimant to provide the information. TakeCare shall accept and acknowledge Urgent Care Claims orally and may also provide its determination in these situations orally to the Claimant. Written notification of the Internal Appeal Determination shall be provided to Claimant within three (3) calendar days of any oral determination made by TakeCare.

c. Expedited External Appeal. Under certain circumstances, a Claimant with an Urgent Care Claim or a Concurrent Care Extension Claim may be allowed to proceed with an Expedited External Appeal at the same time as the Internal Appeal Process. The procedure to initiate a simultaneous Expedited External Appeal is further described below in TakeCare's External Appeal Process.

d. Dental Health Plans Excepted. Adverse Benefit Determinations arising under Medical Health Plans only are subject to the Internal and External Appeal Processes. Adverse Benefit Determinations arising under Dental Health Plans are not subject to the External Appeal Process.

2. Procedure to Request Internal Appeal.

a. Request for Appeal Form. You may file an Internal Appeal by sending a Request for Appeal Form to the Appeals Coordinator, TakeCare Customer Service Department by faxing the request to (671) 647-3542; sending it by mail to P.O. Box 6578, Tamuning, Guam 96931; or by hand delivery at Baltej Pavilion, Suite 108, 415 Chalan San Antonio, Tamuning, Guam 96913. A Request for Appeal Form is attached to the Notice of Claim of Denial or Adverse Benefit Determination form or is available from TakeCare's Customer Service Department. If you have any questions or concerns about or during the Internal Appeal process, you may contact the TakeCare Customer Service Department at (671) 647-3526.

b. Additional Information. You are not required to submit additional information to support the appeal. However, it may be helpful to include any additional information you have to clarify or support the request. For example, you may want to include medical records or physician opinions in support of the request. TakeCare shall provide you, upon request and free of charge, access to and copies of all information and documentation in its possession relevant to the appeal. You will be provided, free of charge, any new or additional evidence considered, relied upon, or generated by TakeCare in connection with the appeal, or any new or additional rationale for a denial during the Internal Appeal process. In such an event, TakeCare shall provide a reasonable opportunity for you to respond to such new evidence or rationale.

c. Urgent Care Claim. If the appeal is an Urgent Care Claim, please see Section A(1)(b) above of this Internal Appeal Process.

3. Review by Appeals Committee for Non-Urgent Care Claims.

a. If a timely non-urgent care appeal is filed with TakeCare within one hundred eighty (180) calendar days of receiving an Adverse Benefit Determination, the appeal will be reviewed by an Appeals Committee consisting of no less than three (3) individuals at TakeCare who were not involved in the initial Adverse Benefit Determination and who are not direct subordinates of those individuals. If the appeal of any Adverse Benefit Determination is based in whole or in part on medical judgment, including whether a given treatment is experimental, investigational, or not medically necessary or appropriate, the Appeals Committee will have as a member a health care professional or in the alternative will consult with a health care professional with training relevant to the claim.

b. For non-urgent care appeals, you will have the option of appeal without a hearing or an appeal with a hearing during which you may appear in person and present evidence or testimony before the Appeals Committee. When filing the Request for Appeal Form, you must indicate whether or not a hearing is being requested. If you fail to indicate whether or not you want a hearing, TakeCare will proceed as if you have opted not to have a hearing.

Even if you do not request a hearing, you may still submit relevant facts and additional evidence in support of the appeal to the TakeCare Customer Service Department.

c. TakeCare shall acknowledge receipt of the appeal in writing within five (5) calendar days of its filing. If the appeal is to be presented in a hearing before the Appeals Committee, the acknowledgement letter will also notify the Claimant of the date and time of the hearing. If the date and time of the hearing are not convenient for you, you may contact the Appeals Coordinator, TakeCare Customer Service Department prior to the designated hearing date, waive the time frame for TakeCare's appeal determination and reschedule the hearing date.

d. If the appeal is a Concurrent Care Claim due to a reduction or termination of services, TakeCare shall acknowledge receipt either orally or in writing, as the case may permit. In such a case, TakeCare shall give the Claimant notice and sufficient time in advance of the reduction or termination of services to appeal and time to receive a decision of the appeal before any interruption of care occurs.

e. Provided that all necessary information is provided when the appeal is made, TakeCare will notify you in writing of the Appeals Committee's determination within fifteen (15) calendar days of receipt of an appeal for a Pre-service Claim or within thirty (30) calendar days of receipt of an appeal for a Post-service Claim.

f. If additional information is needed before the appeal can be determined, a delay in the Appeals Committee making a determination may occur. If the delay is due to circumstances beyond TakeCare's control, in the case of a Pre-service Claim, TakeCare shall notify you prior to the expiration of the original fifteen (15) calendar-day period that it intends to extend the time to make a decision for an additional fifteen (15) calendar days. Likewise, in the case of a Post-service Claim, TakeCare shall notify you prior to the expiration of the original thirty (30) calendar-day period that it intends to extend the time to make a decision for an additional fifteen (15) calendar days. If the Claimant fails to submit necessary information to decide the claim, TakeCare shall notify the Claimant of the specific information that is needed within five (5) calendar days for a Pre-service Claim and within thirty (30) calendar days for a Post-service Claim. For a Pre-service Claim, the notification may be oral, unless the Claimant requests written notification. If the extension is due to the failure of the Claimant to submit necessary information, the Claimant shall have sixty (60) calendar days to submit the requested information. As a result, a Pre-service Claim may be considered within ninety (90) calendar days, and a Post-service Claim may be considered within one hundred and five (105) calendar days.

g. If the appeal is denied, TakeCare shall issue a Notice of Denial of Internal Appeal advising the Claimant of the Internal Appeal Determination. The Notice will state the reasons for the denial including reference to specific plan provisions, guidelines and protocols as a basis for the decision, or an explanation of the scientific or clinical judgment used in confirming the initial Adverse Benefit Determination. If the advice of a health care professional was relied upon during the deliberation of the appeal, the Notice will identify the professional.

h. If the appeal is denied, the Claimant shall be deemed to have exhausted the remedies available under TakeCare's Internal Appeal Process and may file an External Appeal of the Internal Appeal Determination as provided in Section IV below. If TakeCare fails to strictly adhere to its Internal Appeal Process, the Claimant shall be deemed to have exhausted the remedies available under the Internal Appeal Process, and the Claimant may initiate the External Appeal Process in Section IV below or court action, as applicable, unless the violation was: (1) de minimis; (2) non-prejudicial; (3) attributable to good cause or matters beyond the plan's or issuer's control; (4) in the context of an ongoing good-faith exchange of information; and (5) not reflective of a pattern or practice of non-compliance. The Claimant is also entitled to pursue any available remedies under section 502(a) of ERISA or under local law, as applicable, on the basis that TakeCare has failed to provide a reasonable Internal Appeal Process.

1. Notice.

TakeCare shall deliver written notice of the Internal Appeal Determination to the Claimant by its deposit in the United States Mail via certified mail return receipt requested, or by personal delivery to the Claimant within the time frames provided in Section III(A)(3) above. If sent by mail, the notice shall be deemed to be delivered on its deposit in the United States mail. Such notice shall be addressed to the Claimant at his or her address as shown in TakeCare's records. Upon written request by a Claimant, TakeCare will deliver written notice of the Internal Appeal Determination to the Claimant electronically or by facsimile.

IV. EXTERNAL APPEAL PROCESS

A. PROCEDURES FOR EXTERNAL APPEAL

1. When to Request an External Appeal.

a. **Time Limit.** You or your Authorized Representative may file a written External Appeal with the External Appeal Examiner ("Examiner") within four (4) months after the date of receipt of a Notice of Denial of Internal Appeal from TakeCare. If there is no corresponding date four (4) months after the date of receipt of such a Notice, then your request must be filed by the first day of the fifth month following the receipt of the Notice. For example, if the date of receipt of the Notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

b. **Dental Health Plans Excepted.** Adverse Benefit Determinations arising under Medical Health Plans only are subject to the External Appeal Process. Adverse Benefit Determinations arising under Dental Health Plans are not subject to the External Appeal Process.

2. Examiner; Independent Reviewer.

a. The Examiner during the External Appeal Process shall be the federal Office of Personnel Management ("the OPM"). The OPM shall designate individuals to conduct the External Appeal that are independent third parties with clinical and legal expertise and with no financial or personal conflicts with TakeCare as determined by the OPM.

3. Procedure to Request External Appeal.

a. **Request for External Appeal Form.** The External Appeal of an Adverse Benefit Determination or an Internal Appeal Determination may be initiated by sending the Request for External Appeal form which is attached to the Notice of Denial of Internal Appeal. The forms are also available at the TakeCare Customer Service Department. The Request for External Appeal may be sent electronically to DisputedClaim@opm.gov; by faxing the request to (202) 606-0036; or by sending it by mail to P.O. Box 791, Washington, DC 20044. If a Claimant has any questions or concerns during the External Appeal Process, the Claimant can call the OPM at the toll free number, (877) 549-8152; the Employee Benefits Security Administration (EBSA) at (866) 444-EBSA (3272); or the Guam Department of Revenue and Taxation, 1240 Army Drive, Barrigada, Guam 96921, (671) 635-1843~46.

b. **Additional Information.** In addition to the Request for External Appeal form, the Claimant may submit additional information concerning a denied claim to the OPM at the mailing address listed above. If the Claimant chooses to submit additional information to the OPM, the additional information will be shared with TakeCare in order to give TakeCare an opportunity to reconsider its denial of a claim. Information concerning the Claimant's right to privacy during the External Appeal Process shall be provided in the Notice of Privacy Act Rights statement attached to the Notice of Denial of Claim or Adverse Benefit Determination, or Notice of Denial of Internal Appeal received from TakeCare.

4. Procedure for Preliminary Review.

When the Examiner receives an External Appeal, the Examiner will contact TakeCare to request information.

a. Within five (5) business days of receipt of an External Appeal by the Examiner, TakeCare must provide the Examiner with all of the documents and any information it considered in making the Denial of Claim or Adverse Benefit Determination, or Internal Appeal Determination including:

- (1) Claimant's certificate of coverage or benefit;
- (2) A copy of the Adverse Benefit Determination;
- (3) A copy of the Internal Appeal Determination;
- (4) A summary of the claim;
- (5) An explanation of TakeCare's Adverse Benefit Determination and Internal Appeal Determination; and

(6) All documents and information considered in making the Adverse Benefit Determination or Internal Appeal Determination including any additional information that may have been provided to TakeCare or relied upon by TakeCare during the Internal Appeal Process.

TakeCare shall provide this information electronically at DisputedClaim@opm.gov; by fax at (202) 606-0036; or by priority mail at P.O. Box 791, Washington, DC 20044.

b. The Examiner will review the information from TakeCare and may request additional information that it deems necessary to the External Appeal. If the Examiner requests additional information, TakeCare shall supply the information as expeditiously as possible and within five (5) business days.

c. If the Examiner determines that a Claimant is not eligible for External Appeal, the Examiner will notify the Claimant and TakeCare in writing.

5. Review Process.

a. The Examiner will review all of the information and documents timely received. In reaching a decision, the Examiner will review the claim *de novo* and not be bound by any decisions or conclusions reached during TakeCare's claims and Internal Appeal Process.

b. The Examiner will forward all documents submitted directly to the Examiner by the Claimant. Upon receipt of any information submitted by the Claimant, the Examiner must within one (1) business day forward the information to TakeCare. Upon receipt of any such information, TakeCare may reconsider its Adverse Benefit Determination or Internal Appeal Determination that is the subject of the External Appeal. Reconsideration by TakeCare will not delay the External Appeal. The External Appeal may be terminated as a result of the reconsideration only if TakeCare decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Internal Appeal Determination and provide coverage or payment. Within one (1) business day after making a decision to reverse, TakeCare will provide written notice of its decision to the Claimant and the Examiner. The Examiner must terminate the External Appeal upon receipt of the notice from TakeCare.

c. The Examiner must provide written notice of the External Appeal Decision as expeditiously as possible and within forty-five (45) days after the Examiner receives the request for the External Appeal. The Examiner must deliver the notice of External Appeal Decision to the Claimant and to TakeCare.

d. The Examiner's External Appeal Decision notice will contain the following:

- (1) A general description of the reason for the request for External Appeal, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial, including denial codes);
- (2) The date the Examiner received the assignment to conduct the External Appeal and the date of the Examiner's decision;
- (3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- (4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- (5) A statement that the determination is binding except to the extent that other remedies may be available under Guam or Federal law to either TakeCare or to the Claimant;
- (6) A statement that judicial review may be available to the Claimant; and
- (7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

e. After an External Appeal Decision, the Examiner will maintain records of all claims and notices associated with the External Appeal Process for six (6) years. The Examiner must make such records available for examination by the Claimant or TakeCare upon request.

6. Reversal of TakeCare's Determination.

Upon receipt of notice of an External Appeal Decision reversing the Adverse Benefit Determination or Internal Appeal Determination, TakeCare immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim, regardless of whether TakeCare intends to seek judicial review of the External Review Decision and unless or until there is a judicial decision otherwise.

B. EXPEDITED EXTERNAL APPEAL

1. Request for Expedited External Appeal. A Claimant may make a written or oral request for an Expedited External Appeal at the time the Claimant receives:

a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the time frame for completion of an Internal Appeal would seriously jeopardize the Claimant's life or health or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an Urgent Care Claim as part of the Internal Appeal Process, or an Adverse Benefit Determination if the Adverse Benefit Determination concerns an admission, availability of care, continued stay, or

health care item or service for which the Claimant received services, but has not been discharged from a facility, and the Claimant has filed a request for a or Concurrent Care Claim involving Urgent Care; or

b. An Internal Appeal Determination if the Claimant has a medical condition where the normal time frame for completion of a standard External Appeal would seriously jeopardize the Claimant's life or health or would jeopardize the Claimant's ability to regain maximum function, or if the Internal Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received services, but has not been discharged from a facility.

2. Procedure to Request Expedited External Appeal.

a. The Expedited External Appeal process shall be administered by the OPM. The Claimant's request for expedited review can be initiated in the same way as a standard External Appeal by calling the toll free number, (877) 549-8152. In addition, a Claimant may request an Expedited External Appeal of an Adverse Benefit Determination or a final internal Adverse Benefit Determination by sending the Request for External Appeal Form which is attached to the Notice of Denial of Claim or Adverse Benefit Determination or which is also available at the TakeCare Customer Service Department electronically to DisputedClaim@opm.gov; by faxing the request to (202) 606-0036; or by sending it by mail to P.O. Box 791, Washington, DC 20044.

b. If a Claimant has any questions or concerns during the Expedited External Appeal Process, the Claimant can call the OPM at the toll free number, (877) 549-8152; the EBSA at (866) 444-EBSA (3272); or the Guam Department of Revenue and Taxation, 1240 Army Drive, Barrigada Guam, (671) 635-1843~46. The Claimant may submit additional information concerning the denied claim to the OPM at the mailing address listed above. If the Claimant does submit additional information to the OPM, the information will be shared with TakeCare in order to give TakeCare an opportunity to reconsider the denial. Information concerning the Claimant's right to privacy during the External Appeal Process was provided in the Notice of Privacy Act Rights statement attached to the Notice of Denial of Claim or Adverse Benefit Determination or Notice of Denial of Internal Appeal from TakeCare.

3. Examiner; Independent Reviewer.

The Examiner during the Expedited External Appeal Process shall be the OPM. The OPM shall designate individuals to conduct the External Appeal that are independent third parties with clinical and legal expertise and with no financial or personal conflicts with TakeCare as determined by the OPM.

4. Procedure for Preliminary Review.

When the Examiner receives a request for an Expedited External Appeal, the Examiner will contact TakeCare to request information.

a. Immediately upon receipt of request by the Examiner, TakeCare must provide to the Examiner all of the documents and any information required under paragraph IV(A)(4).

b. The Examiner will review the information from TakeCare and may request additional information that it deems necessary to the External Appeal.

c. If the Examiner determines that your claim is not eligible for Expedited External Appeal, the Examiner will notify you and TakeCare as expeditiously as possible.

5. Review Process.

a. The Examiner must comply with the requirements set forth in paragraph IV(A)(5)(a).

b. The Examiner will forward all documents submitted directly to the Examiner by the Claimant. Upon receipt of any information submitted by the Claimant, the Examiner must immediately forward the information to TakeCare. Upon receipt of any such information, TakeCare may reconsider its Adverse Benefit Determination or Internal Appeal Determination that is the subject of the External Appeal. Reconsideration by TakeCare will not delay the External Appeal. The External Appeal may be terminated as a result of the reconsideration only if TakeCare decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Internal Appeal Determination and provide coverage or payment. Immediately after reversing the decision, TakeCare must provide notice of its decision to the Claimant and the assigned Examiner. This notice can be provided orally but must be followed up with written notice within forty-eight (48) hours. The Examiner must terminate the External Appeal upon receipt of the initial notice from TakeCare.

c. The Examiner must provide notice of the External Appeal Decision as expeditiously as the medical circumstances require and within seventy-two (72) hours or less (depending on the medical circumstances of the case) once the Examiner receives the request for the External Appeal. The Examiner must deliver the notice of External Appeal Decision to the Claimant and TakeCare. This notice can be initially provided orally but must be followed up in writing within forty-eight (48) hours.

d. The Examiner's External Appeal Decision notice must comply with the requirements set forth in paragraph IV(A)(5)(d).

e. After an External Appeal Decision, the Examiner must maintain records as required in paragraph IV(A)(5)(e).

6. Reversal of TakeCare's Determination.

Upon receipt of notice of an Expedited External Appeal Decision reversing the Adverse Benefit Determination or Internal Appeal Determination, TakeCare immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim regardless of whether TakeCare intends to seek judicial review of the External Review Decision and unless or until there is a judicial decision otherwise.

EXHIBIT G

Hypothetical MLR Illustration

Assumptions	Annual	Monthly
GG FY18 Premium Revenue (10/1/17 - 9/30/18)	\$18,000,000	\$1,500,000
GG FY18 Resulting Loss Ratio (10/1/17 - 9/30/18)	85%	
Assume Take Care does not renew for FY18 plan year		
Other Commercial Premium Revenue earned in CY17	\$30,000,000	
Other Commercial Premium Revenue earned in CY18	\$32,000,000	
Total CY17 Loss Ratio of Commercial Group Business (including GG)	84%	
Total CY18 Loss Ratio of Commercial Group Business (including GG)	85%	

	CY17 MLR Calculation			CY18 MLR Calculation			GG FY18 Plan Year Experience Refund Calculation		
	GG 10/1/17- 12/31/17	Commercial CY17	Total	GG 1/1/18- 9/30/18	Commercial CY18	Total	GG 10/1/17-12/31/17	GG 1/1/18-9/30/18	Total FY18
Estimated Premium revenue earned (Line A)	\$4,500,000	\$30,000,000	\$34,500,000	\$13,500,000	\$32,000,000	\$45,500,000	\$4,500,000	\$13,500,000	\$18,000,000
% to total	13.0%	87.0%		29.7%	70.3%		25.0%	75.0%	
Estimated Net Claims incurred (Line B)	\$3,825,000	\$25,155,000	\$28,980,000	\$11,475,000	\$27,200,000	\$38,675,000	\$3,825,000	\$11,475,000	\$15,300,000
Medical loss ratio (Line B divided by Line A)	85.0%	83.9%	84.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
Target MLR			85%			85%			86%
% below Target MLR			1.0%			0.0%			1.0%
MLR Rebate payable			\$345,000	MLR Rebate payable		\$0	Participating Refund		\$180,000
Portion payable to GG			\$45,000	Portion payable to GG		\$0	Minus MLR already paid		\$45,000
Portion payable to commercial groups			\$300,000	Portion payable to commerc		\$0			\$135,000
							FY17 Plan Year Net Participating Refund payable by 3/31/19		

⇒ Total paid to GG would be:

CY17 MLR	\$45,000
CY18 MLR	\$0
GG Plan FY18 Participating Refund	\$135,000
	\$180,000

The above sample calculation is for illustration purposes only and is based on hypothetical numbers and assumptions.